NOVA SCOTIA
DEPARTMENT OF HEALTH

ANNUAL STATISTICAL REPORT 2000/01

Prepared by Performance Measurement & Health Informatics

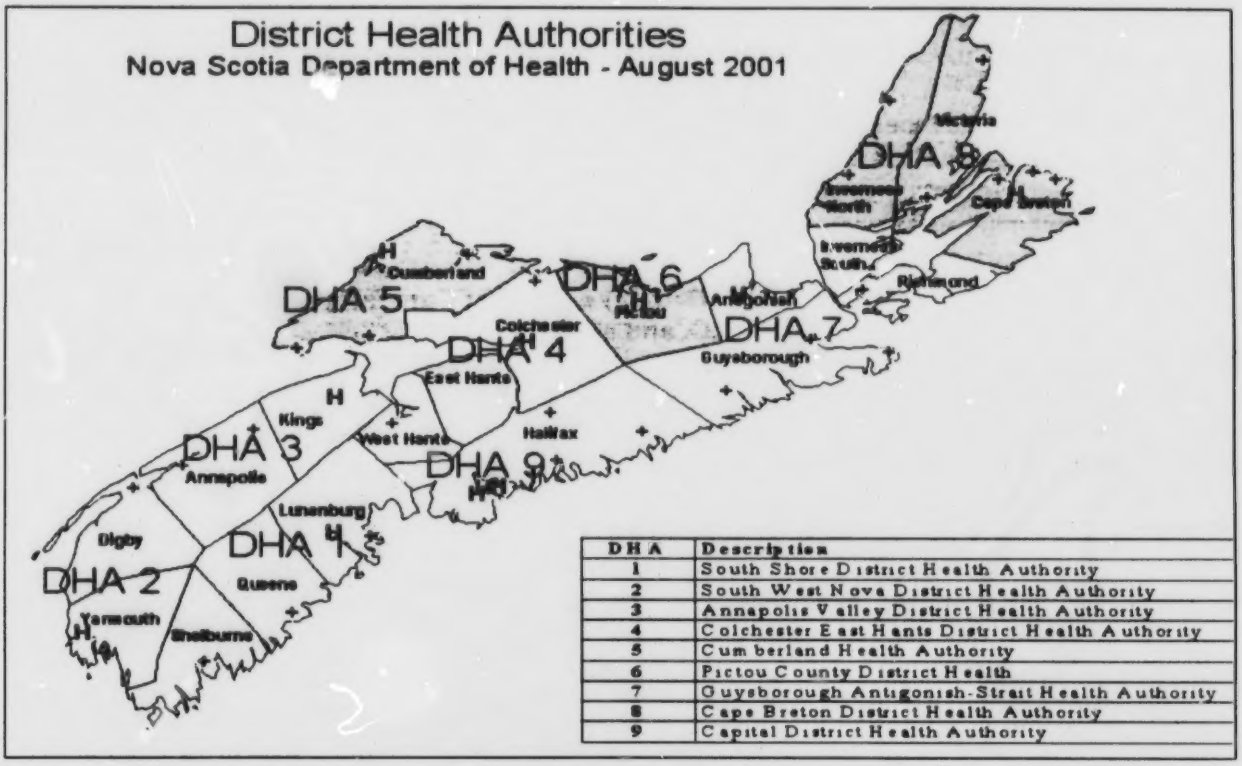
INFORMATION MANAGEMENT BRANCH

September 2001
Revised November 2001

2000/01 Annual Statistical Report

Introduction

The 2000/01 Annual Statistical Report, compiled by the Performance Measurement and Health Informatics Section of the Nova Scotia Department of Health, provides an overview of the Nova Scotia Health System and its components. The information presented is based on existing data and reporting entities and covers a range of program areas including Acute Care, Mental Health, Addiction Services, Tobacco Control, Public Health, Home Care Nova Scotia, Emergency Health, and Insured Programs. A change for this year is the reporting of information by District Health Authority (DHA); the province changed from a regional structure to DHAs.



DHA	Description
1	South Shore District Health Authority
2	South West Nova District Health Authority
3	Annapolis Valley District Health Authority
4	Colchester East Hants District Health Authority
5	Cumberland Health Authority
6	Pictou County District Health
7	Guysborough Antigonish-Strait Health Authority
8	Cape Breton District Health Authority
9	Capital District Health Authority

1. Acute Care Services

There is a wealth of data available on acute care programs and services especially when compared to other sectors of the health care system. Data on acute care services in Nova Scotia have been collected for more than thirty years.

Several traditional indicators of efficiency are reported for the acute care sector - patient days, day surgery rates and procedure volumes.

a) Patient Days and Bed Numbers

Throughout the country patient days and days per thousand have decreased during the 1990's and this pattern continues into the new millennium in the Nova Scotia rates. In the eastern part of the province (DHAs 7&8) residents and hospitals have the highest crude volume of patient days per thousand in the province; the Annapolis Valley area (DHA 3) residents, the lowest. (Please note that the full names of districts can be found on the map above.)

Even with this decrease, Nova Scotia's patient days per thousand population are higher than most other provinces. Each province defines 'acute care' independently so caution is necessary if making interprovincial comparisons. Provinces, such as Ontario, with more chronic care beds and/or facilities have lower acute care patient days per thousand, for example. The inclusion or exclusion of acute care psychiatric days in the acute care database is also a provincial decision, and thus may affect provincial rates.

Acute care bed numbers in Nova Scotia have also been decreasing through this decade, from 5.3 beds per 1000 population in 1992/93 to 3.3 beds in 2000/01. The last available data for interprovincial comparisons, from 1997/98, show that Nova Scotia was at about mid-point at 3.5 beds per 1000 population.

b) Average Length of Stay, Alternative Level of Care, and May Not Require Hospitalization (ALOS, ALC, and MNRH)

The average acute care length of stay (ALOS) had been gradually decreasing from its 1993 high of 9.4 days. Nova Scotia has in turn experienced a slight increase since 1998/99 to 8.5 days in 2000/01. ALOS by DHA of residence is highest in DHAs 8 and 9 at 10.2 and 9.4 days respectively; it is lowest at 6.7 days in both DHAs 3 and 4. Results are similar by DHA of hospitalization.

There is debate about the usefulness of overall average length of stay as an indicator. Lengths of stay for particular patient groups, especially when compared with other facilities or expected lengths of stay, are more commonly used for utilization management at the facility or inter-district level.

Alternate Level of Care (ALC) Days are days of care provided to inpatients who have finished the acute care phase of their treatment or who were admitted for non-acute medical care. A physician or hospital designate must identify a patient as ALC. In Nova Scotia, 7.5 days per 1000 population were designated ALC days. The rate per DHA ranged widely from 2 days per thousand persons in DHA 2 to 150 days per thousand persons in DHA 8. However, it is important to note that differences in rates between facilities, districts, and provinces may reflect differences in reporting practices rather than differences in hospital utilization or patient mix.

In 2000/01, 8% of separations and 4% of acute care days in Nova Scotia are classified as May Not Require Hospitalization (MNRH), i.e., these services could possibly be provided more appropriately in another setting, such as a medical day unit or day surgery clinic.

c) Same Day Admission Surgery, Day Surgery, and Selected Surgical Procedures

Comparisons of the utilization of surgical services are long-standing measures of efficiency and appropriateness.

Performing surgery on the day a patient is admitted to hospital helps to decrease the length of stay. The percentage of elective surgeries performed on the day of hospital admission has increased from 7% in 1990/91 to 86% in 2000/01. Throughout the province the rates vary from 67% in DHA 3 hospitals to 94% in DHA 4.

Limits on the availability of elective beds have also decreased lengths of stay by encouraging the movement of an increasing range of surgical procedures to the day surgery setting. A provincial target of 75% had been set in the early 1990's and all districts have since met this target. Nova Scotia's rate was 76% in 1995/96 and has increased to 86% in 2000/01. By DHA, it ranged from a low of 80% in DHAs 3 and 8 to a high of 93% in DHA 5.

A review of specific procedures highlights changes in surgical practices. It is becoming more common for hernia repairs to be performed in day surgery units; the day surgery rate for hernia repairs has increased from 43% in 1995/96 to approximately 68% in 2000/01. Laparoscopic cholecystectomies account for about 85% of all cholecystectomies compared with 79% in 1995/96 and the percentage of these performed in day surgery has also increased, rising from 11% in 1995/96 to 39% in 2000/01.

In an attempt to adjust for differences in the population distributions of the nine districts, age standardized rates have also been used. Total knee and total hip replacement rates show some fluctuations over time and differences between districts. This year DHA 5 residents had the lowest rate of hip replacements in Nova Scotia at 20 per 100,000, and DHA 3 residents have the highest rate at 80 per 100,000. DHA 5 also has the lowest rate for knee replacements at 42 per 100,000 while DHA 8 has the highest rate at 123 per 100,000. Rates of both procedures in Nova Scotia, and particularly in Cape Breton, were significantly higher than the Canadian rates of 57.0 for hips and 61.4 for knees. It should be noted that DHA 5 residents receiving surgery outside the province, e.g. at Moncton, are not included in these calculations.

Provincial age-standardized hysterectomy rates have decreased from 469 per 100,000 in 1995/96 to 395 per 100,000 in 2000/01. DHA 5 residents have the lowest rate at 275 per 100,000 and DHA 6 residents have the highest rate at 514 per 100,000 population.

d) Cardiovascular Procedures

Provincially, age-standardized cardiac catheterization rates had increased from 149 per 100,000 in 1995/96 to 257 per 100,000 in 1999/2000, although the increase in 99/00 is partially due to improved reporting practices at the QEII. There was a slight decrease overall to 246 per 100,000 in 2000/01 when DHA 6 had the lowest rate at 170 per 100,000 and DHA 9 had the highest at 268 per 100,000.

Angioplasty rates have increased from a rate of 58 per 100,000 in 1995/96 to 93 per 100,000 in 2000/01. Residents of DHAs 1, 8, and 9 had slightly higher age-standardized rates than residents of the other districts in the province.

Coronary artery bypass graft (CABG) rates decreased to 66 per 100,000 in 2000/01 from a high of 81 per 100,000 in 1998/99. In 2000/01 the rates by DHA ranged from 40 per 100,000 in DHA 5 to 78 per 100,000 in DHA 4.

The Divisions of Cardiology and Cardiovascular Surgery at the QEII monitor access to cardiac surgery, and waiting times for these procedures are reported to the Department of Health on a monthly basis. During 2000/01, average waits for urgent cardiovascular procedures met the 7-day standard. With the exception of the final quarter, waiting times for elective or semi-urgent procedures have generally also met the standard in 2000/01.

e) Readmissions to Hospital

Hospital readmission rates have been used to measure the effects of decreasing bed numbers and lengths of stay. The Canadian Institute for Health Information (CIHI) measures readmissions to the same hospital with the same or related diagnosis within 7 and 30 days of hospital discharge. The accuracy of reporting at the hospital level has been a concern and attempts to improve this continue. Variations in district rates may reflect reporting inconsistencies. The provincial readmission rate is 3.7% for one-week and 9.3% for one-month readmissions respectively. Hospitals in the DHA 4 have the highest rates for readmissions within one week, and hospitals in DHA 8 have the highest rates of readmission within one month. Obstetrical cases and newborns are excluded from this indicator. For fiscal 1999/2000, hospitals began collecting readmission data on the basis of whether that readmission was *planned* or *unplanned*.

f) Expected Lengths of Stay (ELOS) for Selected CMGs

Expected lengths of stay (ELOS) for selected CMGs are displayed in this year's report and indicate days over or under the national database mean (Top 10 CMG's over). Comparisons with ELOS are made for the top 5 CMG's by DHA over the national database mean. On the whole, Nova Scotia's length of stay is marginally (less than one day) above the national database's expected length of stay.

g) Rates of Hospitalization for Pneumonia and Influenza, and Ambulatory Care Sensitive Conditions

The rate of hospitalization for pneumonia and influenza in Nova Scotia decreased from 1538 per 100,000 in 1998/99 to 1313 per 100,000 in 2000/01. The rate by DHA ranged from a low of 1009 per 100,000 in DHA 9 to a high of 2062 per 100,000 in DHA 7.

Ambulatory care sensitive conditions are chronic conditions for which appropriate management in an ambulatory care setting has the potential to prevent an acute episode and subsequent hospitalization. These conditions include asthma, diabetes, hypertension, depression, neuroses, and drug- and alcohol- related conditions. Severity and comorbidity are not taken into account.

The age-standardized rate of hospitalization for such conditions in Nova Scotia was 453 per 100,000 in 1998/99 and decreased to 350 per 100,0000 in 2000/01.

h) Inflow / Outflow Ratio

The inflow / outflow ratio is a measure of the relative flow of patients residing in one district to hospitals in other districts. A ratio of greater than one means that more patients are coming in to district hospitals from other districts, than are going from the district to hospitals in other districts. A ratio of less than one means that more patients who reside in the district are being treated in hospitals in other districts.

Most Nova Scotia districts had ratios of less than one in 2000/01, indicating that they were sending out more patients than they were taking in. Districts 3 and 8 had ratios of 1.03 and 0.94 respectively, indicating that they had similar numbers of patients coming and going out, while DHA 9 had a ratio of 1.43. This is to be expected as this district provides tertiary services to the entire province and often to the Maritime Provinces as a whole.

2. Mental Health Programs

The World Health Organization, in reflecting on the global burden of disease, has noted that five of the top ten causes of disability as measured by severity and duration are mental illnesses. Twenty-six percent of workers report stress and mental or emotional health problems as a result of their work (as opposed to 9% for other injury or illness) costing business and employees an estimated $5 billion dollars per year in Canada. Over 18% of children have at least one diagnosable psychiatric disorder.

- Mental Health Services, NS DoH

a) Inpatient Separations, Patient Days, and Length of Stay

Inpatient acute care separations and patient days provide a measure of the utilization of mental health programs. The volume of separations for diagnostic groups, e.g. Mood Disorders, shows the likelihood of encountering certain conditions in the clinical setting. The Nova Scotia Hospital and designated in-patient units at Colchester, Aberdeen, the IWK, QEII HSC, Health Services Association of the South Shore, Yarmouth, Valley Regional, St. Martha's, and Cape Breton Health Care Complex provide in-patient acute care mental health programs.

In 2000/01 the most often encountered diagnostic groups for adults (19 years of age and older) were mood disorders, schizophrenia and psychotic disorders, adjustment disorders, substance related disorders, and personality disorders. For children, the diagnoses most commonly treated on in-patient units were: mood disorders, schizophrenia and psychotic disorders, attention-deficit and disruptive behavior disorders, adjustment disorders, and substance related disorders. The treatment of mood disorders and schizophrenia/psychotic disorders accounted for the largest number of days for adults; schizophrenia/psychotic disorders and eating disorders accounted for the largest number of days for children.

The number of acute inpatient days per 1000 population for Nova Scotia in 2000/01 was 85.0. The value varied widely by DHA with 5.8 days per 1000 population in DHA 2 and 173.8 days per 1000 population in DHA 8.

The numbers of separations for adults decreased from 4681 in 1995/96 to 3247 in 2000/01. Patient days increased from 72,986 to 74, 384 in the same years. The average length of stay for adults increased from 15.9 days in 1996/97 to 22.9 days in 2000/01.

ALOS for all patients was shortest in at 9.1 days DHA 6, and longest at 27.3 days in DHA 8 where the discharge of several long stay (greater than one year) patients resulted in unusually high "patient days" for this year.

The numbers of separations for children decreased from 586 in 1995/96 to 315 in 2000/01. Patient days also decreased from 8228 to 5830 in the same years.

b) Outpatient Clinics and Ambulatory Care (Youth and Adults)

Outpatient mental health clinics provided services to over 26,400 clients in 2000/01. The most common adult diagnoses treated in these clinics were mood disorders, miscellaneous anxiety disorders, adjustment disorders, 'diagnosis deferred', and schizophrenia. For clients under the age of 18 the most frequent diagnoses were 'diagnosis deferred', adjustment disorders, relation abuse, attention deficit/hyperactivity disorders, and miscellaneous anxiety disorders. 'Diagnosis deferred' is used for a number of reasons and may indicate difficulty making a diagnosis on a client who has

only attended once or that the Mental Health Outpatient Information System (MHOIS) has not been updated as the chart was updated.

There has been an overall increase in ambulatory care program utilization since 1993/94. There was an average 29 active clients per 100,000 population in 2000/01 as compared to 24 per 100,000 in 1993/94. These clients made and average of 5.4 visits in 2000/01, up from 4.9 visits per client in 1993/94

3. Addictions Services

a) Number of Clients Served by Gender and Service Utilization Breakdown

Data regarding the number of clients in Addiction Services programs illustrate a steady increase in the utilization of services from 1992/93 to 1997/98 for both men and women. There was a slight decrease in volume in 1998/99 and 1999/2000 and a slight increase in 2000/01.

Outpatient (O.P.D.) and Detoxification Services were the most utilized programs in Addiction Services.

4. Public Health Programs

a) Percentage of Women Known to be Breast Feeding at the Time of Hospital Discharge

The percentage of women known to be breast-feeding at the time of hospital discharge has increased gradually but steadily since 1994. However, in 1999 and in 2000, Nova Scotia women were breast feeding at a rate of 64%[1] which is both less than the Canadian 1994 rate (74%) and the Nova Scotia year 2000 target rate (75%).

b) Percentage of Seniors Vaccinated Against Influenza

The percentage of seniors vaccinated against influenza was on the rise through 1995/96. The rate declined slightly in 1997/98 and 1998/99 but increased again in 1999/2000 and 2000/01. Changes in how immunizations are reported may account for some of the reduction in the rate.

Nova Scotia is quite close to meeting the national target level of 70%.

c) Infectious Disease Rates

In addition to tracking health promotion activities such as vaccinations and breast-feeding rates, Public Health programs also monitor infectious disease rates in Nova

[1] Data for 2000 are incomplete, Nova Scotia Reproductive Care Program

Scotia. Chlamydia rates increased in 1998 through 2000 following a steady decline since 1991. AIDS incidence rates decreased with a rate 0.3 per 100,000 in 2000. HIV incidence rates showed a similar decrease from 4.2 per 100,000 in 1995 to 1.8 per 100,000 in 2000. There are very small numbers of cases for all three conditions and changes in rates can be, therefore, somewhat misleading.

5. Tobacco Control

Tobacco use is the number one public health problem adversely affecting Nova Scotians. Over 1400 Nova Scotians die annually as a direct result of smoking and it is estimated that another 80 Nova Scotians die due to exposure to second-hand smoke. Nova Scotia men and women have the second highest rates of lung cancer mortality in the country (1998 National Cancer Institute, Cancer Statistics Annual Report).

The Tobacco Control Unit works in partnership with schools, businesses, provincial and community organizations, and other government departments (e.g. Education, Finance, Tourism), to deliver a comprehensive tobacco control strategy for the province. Key components of this strategy are: Public Education; Legislation/Policy and Enforcement; Health Promotion Programming; and Resources, Training, Monitoring, and Evaluation.

For example, all school boards in the province have had in-service workshops on a Smoke-Free for Life Tobacco Education Curriculum for grades Primary to 9. The province's three tobacco control inspectors enforce the Tobacco Access Act that prohibits tobacco sales to minors less than 19 years of age, as well as enforcing federal tobacco legislation.

a) Smoking Rates

Smoking rates are high among the adult Nova Scotian population (30.0%), among pregnant women (25.0%); and among youth (36.0%).

b) Retailer Compliance with Tobacco Laws

In 2000/01, 46.9% of Nova Scotia's retailers inspected were found to be in compliance with the law - this compares favorably with last year's value of 33.3%. The former Western Region had the highest compliance rate at 55.8%.

c) Environmental Tobacco Smoke

The prevalence of environmental tobacco smoke (ETS) is a concern to non-smokers and health professionals alike. While Nova Scotia's rate for persons living with a smoker who regularly smokes indoors is comparable with the other Atlantic Provinces and has decreased significantly from its value of 42% in 1996/97, it is still quite high at 30% in 2000/01.

6. Home Care Nova Scotia

a) Caseload, Admissions, and Home Oxygen

Home Care Nova Scotia had experienced a gradual increase in the numbers of clients during the period of 1995/96 through 1999/00. In 2000/01, there was slight decrease in the number of clients. Capital District, which has the highest population, had the greatest number of cases (7475) while DHA 8 had the lowest (968) number of cases and population. The Capital Health District also had the highest number of admissions at 4,166 while DHA 5 had the lowest at 319.

Home Care Nova Scotia has two service components: chronic Home Care services and acute Home Care services. Chronic Home Care services are designed to meet the assessed needs of clients needing prolonged care, whereas acute Home Care services are designed to meet the needs of those people leaving hospital who need immediate help for a relatively short period of time.

Admissions to chronic home care services had increased from 6,701 in 1996/97 to 8,794 in 1999/2000, but decreased to 8,151 in 2000/01. Acute home care admissions rose steadily over the same period, increasing from 466 in 1996/97 to 1,960 in 2000/01.

Chronic Home Care services had more admissions than acute Home Care services in all Districts over the last five fiscal years. The number of admissions to acute Home Care services, in most of the Districts, has steadily increased since 1995/96.

Home oxygen is provided through chronic Home Care services. DHA 8 had the most 'new starts' on home oxygen at 136, and DHA 6 had the fewest at 18.

7. Emergency Health Services

a) Government Subsidized Patient Transfers and Out of Hospital Cardiac Arrest Survival Rates

Emergency health services that are provided by Nova Scotia Emergency Health Services are funded by the Department of Health and through users' fees. The volume of local emergency medical ambulance services increased during 2000/01; long distance volumes also increased except for Central, which showed a slight decrease.

Response times, measured from the moment a call is received, to the dispatching of an emergency vehicle, to the vehicle's arrival at the emergency scene, are critical to the victim's well-being and/or survival in an emergency situation. Nova Scotia Emergency Health Services has demonstrated a consistent response time of around 1 minute from call to dispatch. The monthly average time from dispatch to arrival at scene has ranged from 8 minutes 37 seconds in March 2001 to 9 minutes 39 seconds in July 2000. The

numbers of emergency and non-emergency transports indicate that vehicle utilization has remained constant for 2000/01.

Knowing what types of emergency situations Emergency Health Services personnel encounter can help them prepare for future needs. In 2000/01 the top five chief complaints from emergency calls were, in descending order: breathing problems, fall/back injuries, 'sick persons', traffic accidents, and chest pain.

Emergency Health Services receives and responds to out-of-hospital cardiac arrest calls. Successful treatment of out-of-hospital cardiac arrests requires the immediate response of trained paramedics and first responders. Survival means that the victim remains neurologically intact and regains cardiac rhythm. In 1997, Emergency Health Services had a 4.0% survival rate; in 2000, 6.9% of out-of-hospital cardiac arrests survived.

Volumes are reported for the EHS LifeFlight air ambulance program again this year. This program is developing a broader range of indicators. A 'mission' is any call where the LifeFlight medical team has had patient contact and generated a patient care record. The numbers of missions have almost doubled since the start of the program in 1996/97. Almost 82% of LifeFlight missions are interfacility, which means that the request for transport originates at a health care facility and the patient is picked up from the health care facility, and 8% were at the scene. Most missions were for adults and 86% were for Nova Scotians, 10% were for PEI, 3% were for New Brunswick, and finally 1% was for other locales.

8. Expenditures for Insured Services

Insured services include Medicare, dental, prosthetics, optometric, and prescription drugs. The total expenditure for all of these programs (not including administration expenses) was $365.1 million in 1996/97, and increased to $478.3 million in 2000/01. *

Additional information for the Medicare, Pharmacare, and Children's Oral Health programs is included below. Since 1991/92, expenditures for these programs have risen slightly.

** It should be noted that all 2000/01 figures are preliminary estimates.*

a) Medicare

Medical expenditures can be measured by examining the cost and number of services provided by physicians to patients. Since 1997/98 the number of physicians' services per beneficiary (a beneficiary is a person with a Nova Scotia Health Card Number who has received services during the fiscal year) has risen slightly from 8.7 in 1997/98 and 1998/99 to 9.0 in 2000/01. Expenditures per beneficiary for physician services have risen from $339.25 in 1997/98 to $455.74 in 2000/01.

The total number of physicians in Nova Scotia has risen from 1,798 in 1996/97 to 1,931 in 1999/00.

The total number of general practitioners under fee-for-service had declined from 900 in 1997/98 to 785 in 1999/2000, but has increased to 812 in 2000/01. The number of general practitioners in rural areas has remained constant at about 49% of all general practitioners in the province from 1997/98 to 1999/2000 (locums excluded).

In 1996/97 there was one physician for every 518 (insured) residents of the province. By 1999/00 there was one physician for every 486 residents.

In 2000/01 there was one licensed general practitioner for every 1159 residents.

b) Pharmacare

Pharmacare services are provided to Nova Scotia residents 65 years and older. Changes in the number of prescriptions per beneficiary and the cost of those prescriptions are used to show changes in Pharmacare program utilization. The expenditures per beneficiary have increased by approximately $250.00 since 1997/98 while the overall number of prescriptions per beneficiary increased from 26.5 to 29.5 during the same time period.

c) Children's Oral Health

The Nova Scotia Children's Oral Health Program, funds a range of dental health services to children under the age of 10. In Nova Scotia the percentage of young children (3 to 9 years) receiving annual dental check-ups increased slightly in 2000/01 to 59% after decreasing during the period 1996/97 through 1999/00. The rate was lowest in DHA 2 at 47% and highest in DHA 3 at 73%.

The average number of restorations per insured person had decreased during the period 1991/92 through 1999/2000 but increased to 0.73 per child in 2000/01. DHA 2 residents had the highest rates of dental restorations per insured and DHA 9, the lowest.

9. Women's Health

a) Caesarean Sections, Breast Cancer Screening/Incidence/Mortality, and Cervical Cancer Incidence/Mortality Rates

Caesarean sections, breast screening, breast cancer mortality, and gynecological cancer screening and mortality rates have been chosen to illustrate some women's health issues.

Nova Scotia's rate of Caesarean sections per 100 deliveries has been increasing since 1969/70. In 2000/01 the rate was 23.3%. DHAs 3 and 5 had the lowest rates (18.1%) while DHA 6 had the highest at 28.9%.

The percentage of women aged 50 to 69 who were screened for the first time for breast cancer has decreased to 3.4% in 2000/01 from 4.0% in 1998/99. Mobile screening units have increased access throughout the province. Nova Scotia's breast cancer incidence rate has been increasing over time; it was 83.3 per 100,000 women in 1980 and has increased steadily to 104.2 per 100,000 women in 2000. The breast cancer mortality rate, which was 25 deaths per 100,000 women in 1950, had been increasing since then to 34 per 100,000 women in 1998. However the rate decreased to 29 in 1999 and 2000. The Canadian rate for 2000 was 27.

Even with a small increase in 1998 and 1999, Nova Scotia's cervical cancer incidence rate has been decreasing over time; it was 10 per 100,000 women in 2000. The mortality rate had increased from 3.4% in 1994 to 3.8% in 1998, but dropped to 3.0% in 2001. This rate is slightly higher than the Canadian rate of 2.2% in 2000.

10. Conclusion

These indicators have provided a brief overview of Nova Scotia's health care system in 2000/01. Any comments, questions, or requests for additional copies should be directed to Jimi Kaye (424-6881) at the address below.

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SLIDE SHOW

ANNUAL STATISTICAL REPORT

2000/01

Prepared by Performance Measurement
& Health Informatics
Information Management Branch
Nova Scotia Department of Health

ANNUAL REPORT - DATA NOTES

A Guide to Using the Data

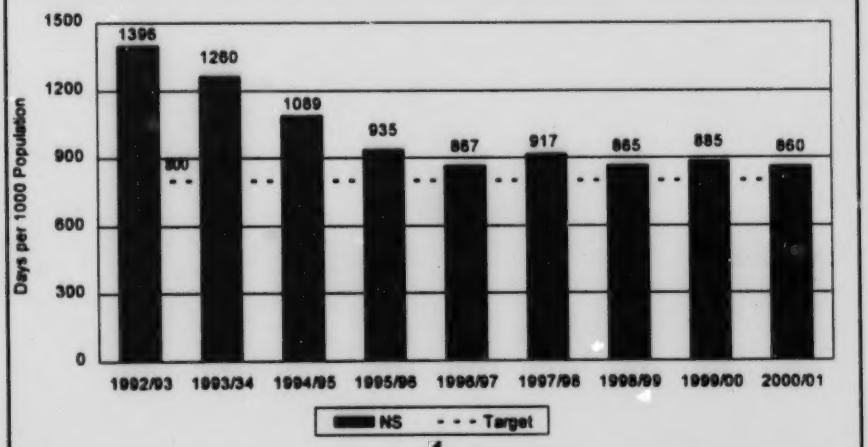
- The Annual Report is designed to be read in the following order: Introduction, Slides, then Data Dictionary.
- The Introduction provides a brief analysis of the contents of the slide show as well as relevant background information.
- The Data Dictionary provides technical background and formula inclusions and exclusions, as well as the source for the data.

ACUTE CARE

3

PATIENT DAYS PER 1000 POPULATION

Nova Scotia - 1992/93 to 2000/01- Excludes Newborns



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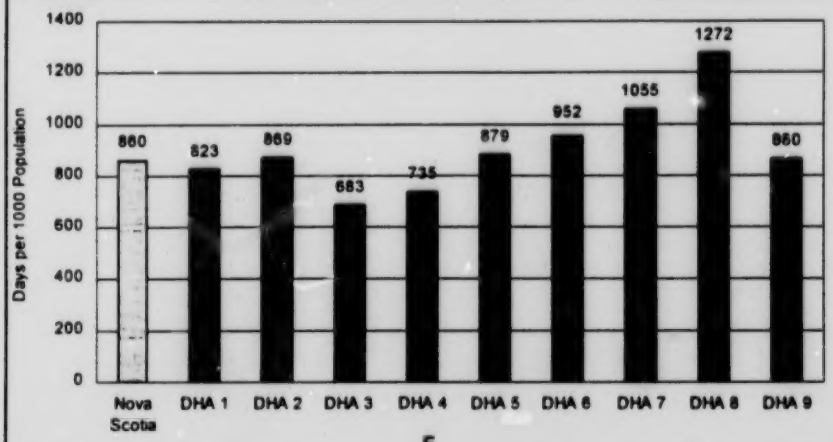
PATIENT DAYS PER 1000 POPULATION

Crude Rates Per 1000 Population by DHA of Residence 2000/01 Excludes Newborns



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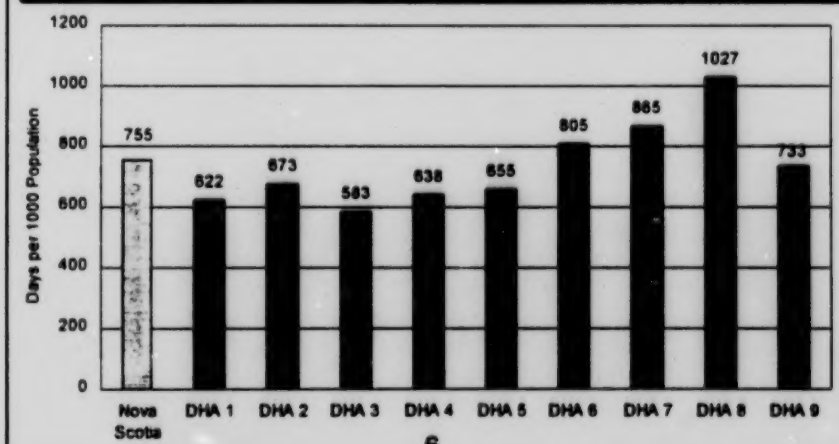
PATIENT DAYS PER 1000 POPULATION

Days Per 1000 Population Age-Standardized to the 1991 Canadian Population by DHA of Residence 2000/01 Excludes Newborns



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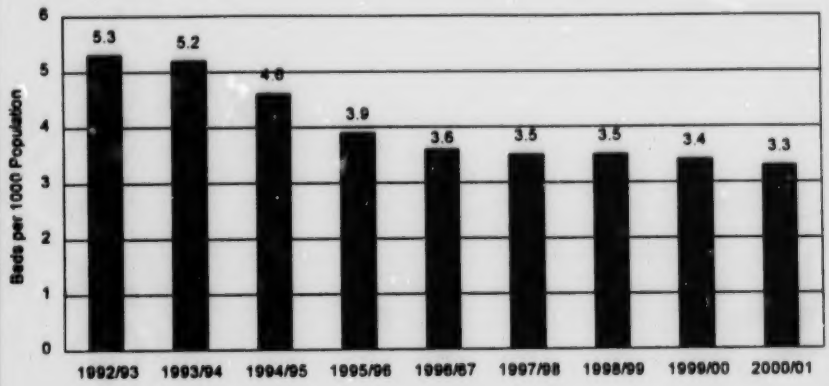
BEDS PER 1000 POPULATION

Nova Scotia - 1992/93 to 2000/01



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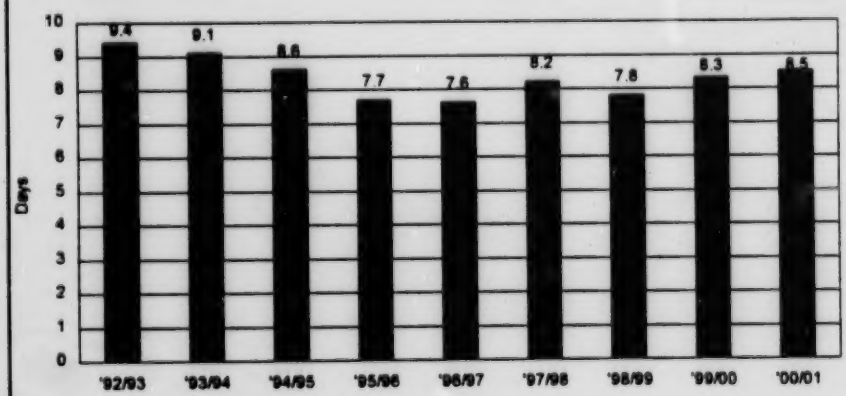
AVERAGE LENGTH OF STAY

Acute Care

Nova Scotia - 1992/93 to 2000/01 - Excluding Newborns



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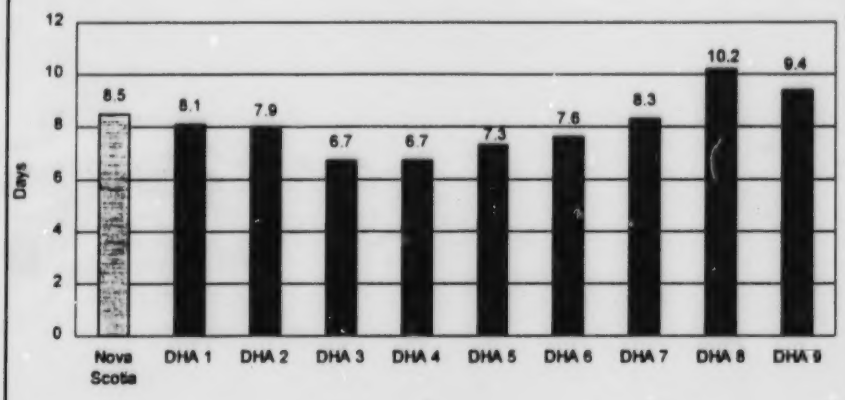
AVERAGE LENGTH OF STAY

Acute Care

by DHA of Residence - 2000/01 - Excluding Newborns



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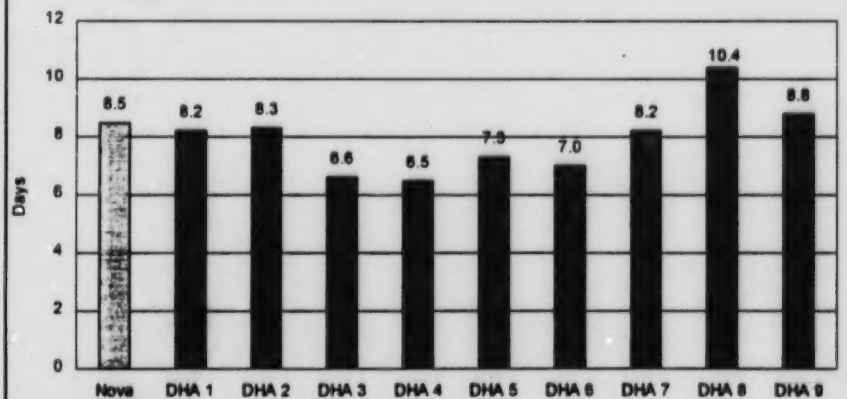
AVERAGE LENGTH OF STAY

Acute Care

by DHA of Hospitalization - 2000/01 - Excluding Newborns



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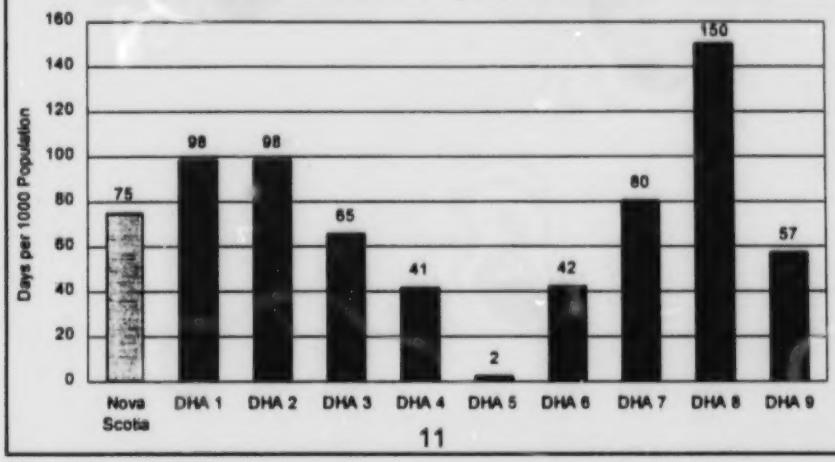
ALTERNATE LEVEL OF CARE (ALC) DAYS PER 1000 POPULATION

Crude Rates Per 1000 Population by DHA of Residence 2000/01



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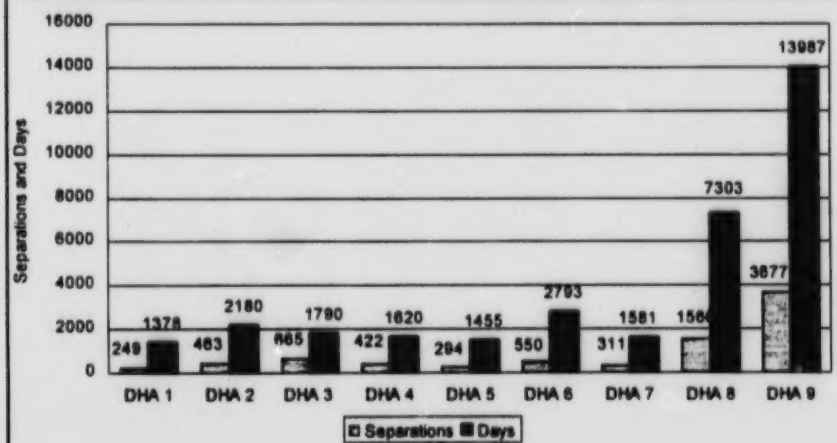
MAY NOT REQUIRE HOSPITALIZATION (MNRH)

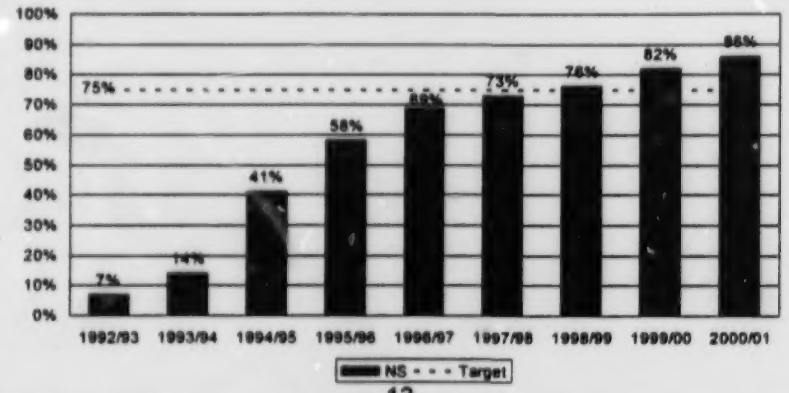
Separations and Days - By DHA of Hospitalization 2000/01



12

ELECTIVE SURGERY - PERCENTAGE PERFORMED ON THE DAY OF HOSPITAL ADMISSION

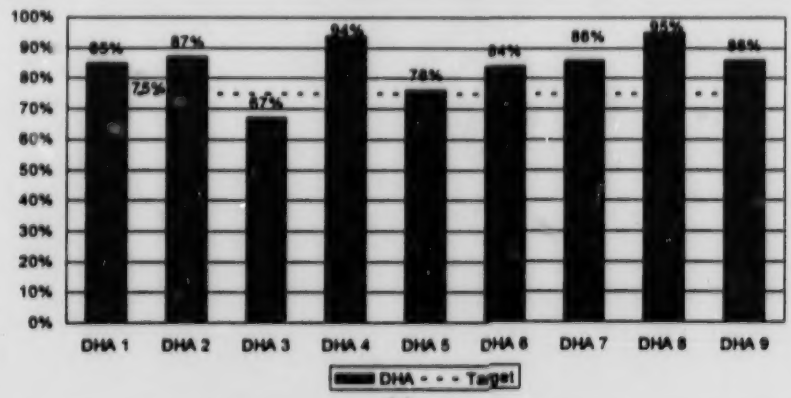
Nova Scotia - 1992/93 to 2000/01



13

ELECTIVE SURGERY - PERCENTAGE PERFORMED ON THE DAY OF HOSPITAL ADMISSION

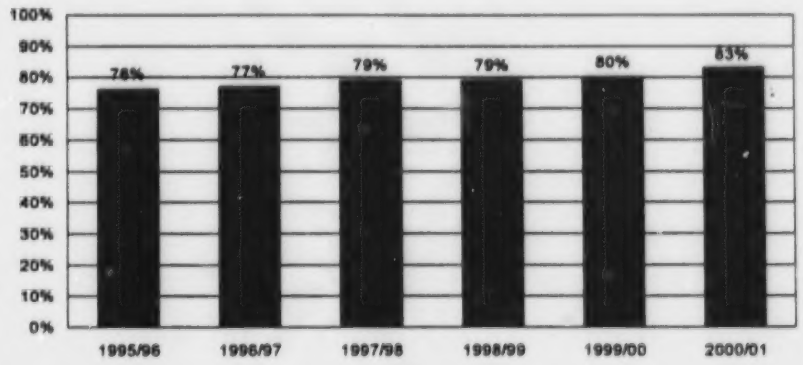
by DHA of Hospitalization - 2000/01



14

ELECTIVE DAY SURGERY AS A PERCENTAGE OF ALL ELECTIVE SURGERY

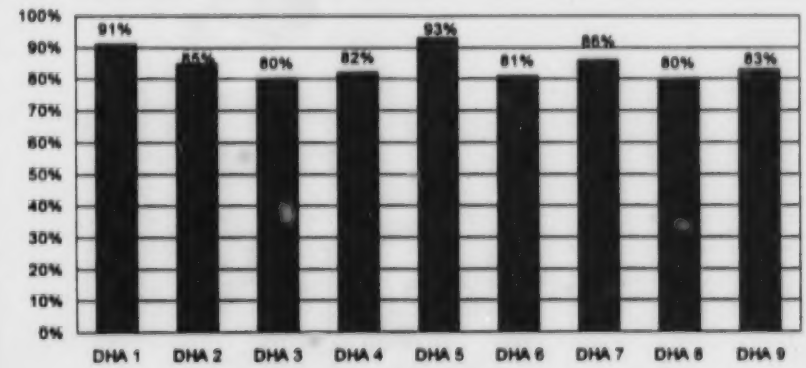
Nova Scotia - 1995/96 to 2000/01



15

ELECTIVE DAY SURGERY AS A PERCENTAGE OF ALL ELECTIVE SURGERY

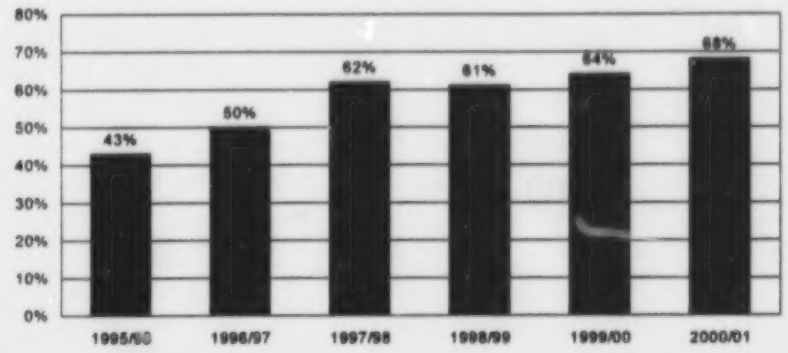
by DHA of Hospitalization - 2000/01



16

INGUINAL/FEMORAL HERNIA REPAIRS - PERCENTAGE DONE AS DAY SURGERY

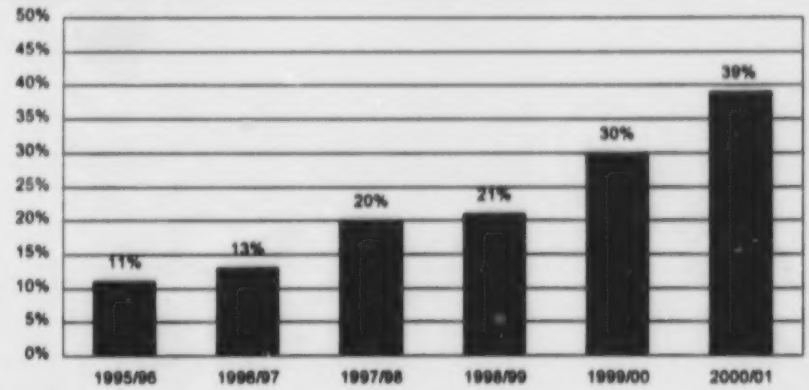
Nova Scotia - 1995/96 to 2000/01



17

LAPAROSCOPIC CHOLECYSTECTOMIES

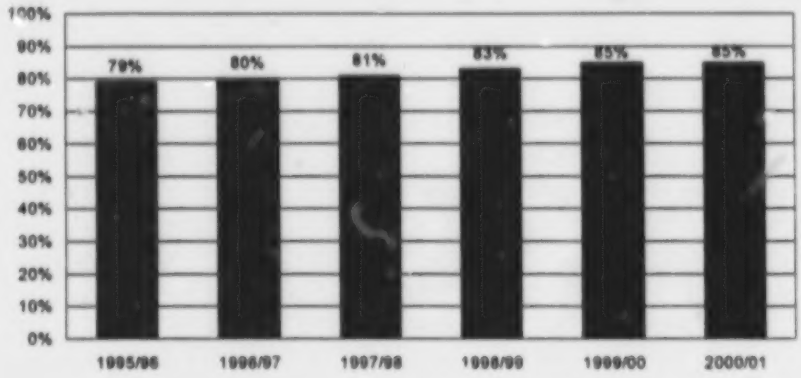
Percentage Performed as Day Surgery
Nova Scotia - 1995/96 to 2000/01



18

LAPAROSCOPIC CHOLECYSTECTOMIES

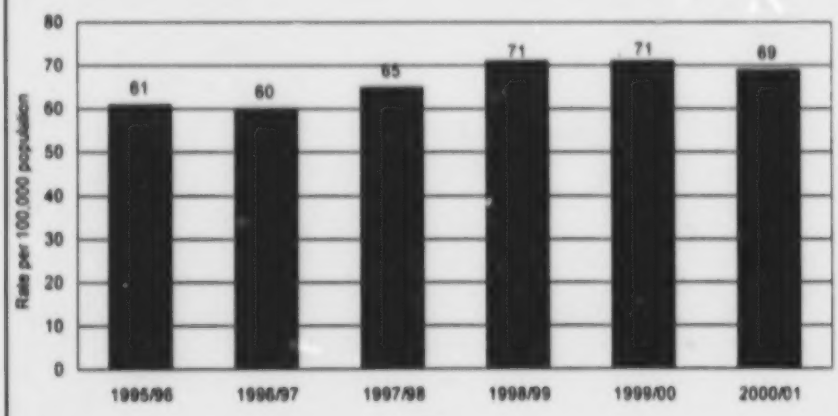
As a Percentage of All Cholecystectomies
Nova Scotia - 1995/96 to 2000/01



19

TOTAL HIP REPLACEMENTS

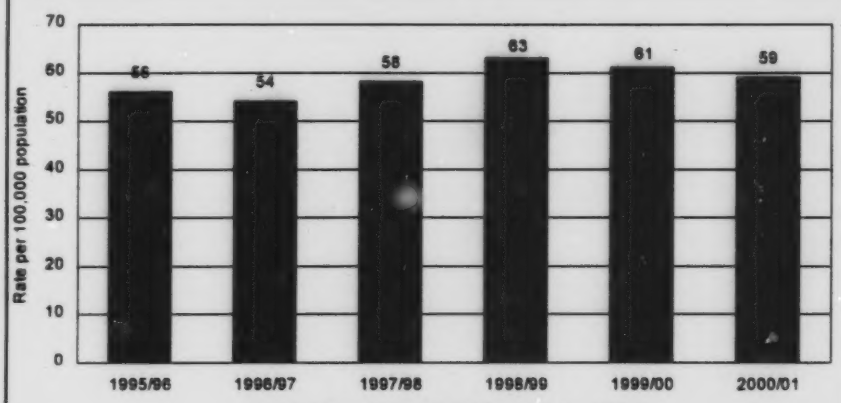
Crude Rates Per 100,000 - Nova Scotia - 1995/96 to 2000/01



20

TOTAL HIP REPLACEMENTS

Rates Per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia 1995/96 to 2000/01

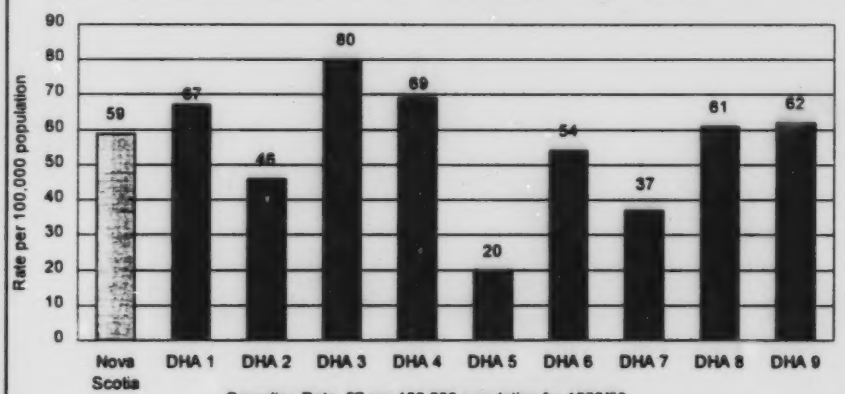


Canadian Rate: 57 per 100,000 Population for 1998/99

21

TOTAL HIP REPLACEMENTS

2000/01 Rates Per 100,000 Age-Standardized to the 1991 Canadian Population - by DHA of Residence

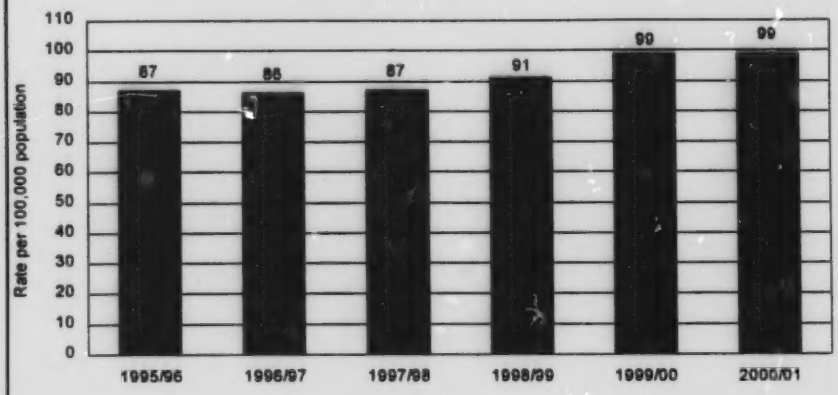


Canadian Rate: 57 per 100,000 population for 1998/99

22

TOTAL KNEE REPLACEMENTS

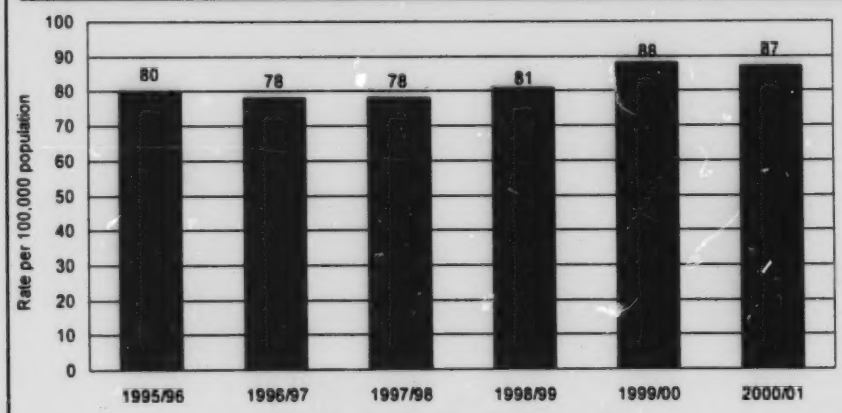
Crude Rates Per 100,000 - Nova Scotia - 1995/96 to 2000/01



23

TOTAL KNEE REPLACEMENTS

Rates Per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia -1995/96 to 2000/01

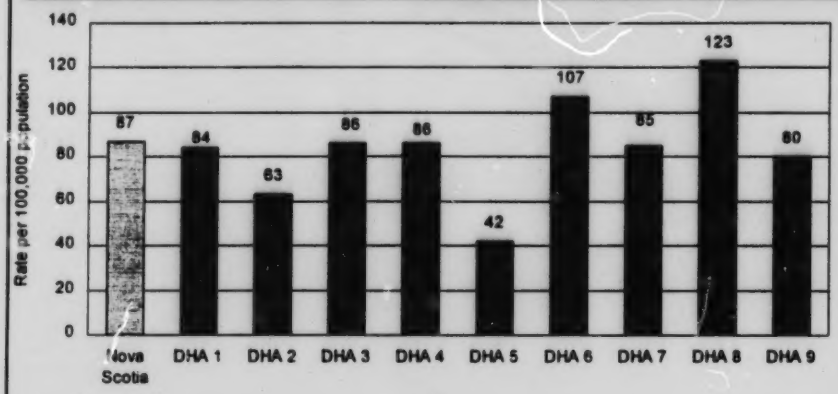


Canadian Rate: 61 per 100,000 Population for 1998/99

24

TOTAL KNEE REPLACEMENTS

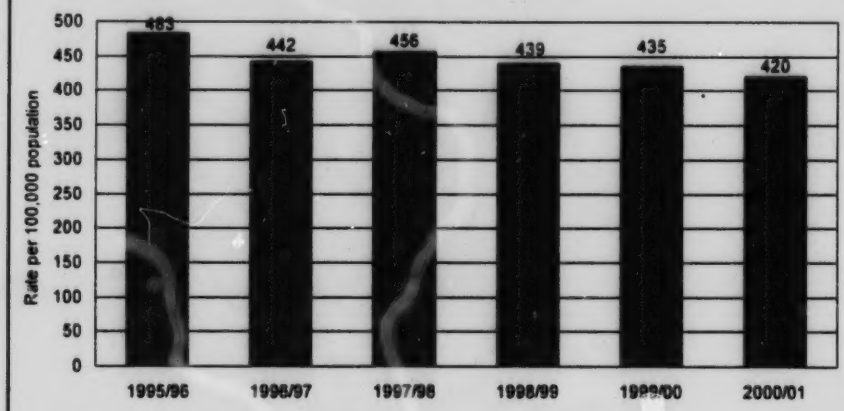
2000/01 Rates Per 100,000 Age-Standardized
to the 1991 Canadian Population - by DHA of Residence



25

HYSTERECTOMIES

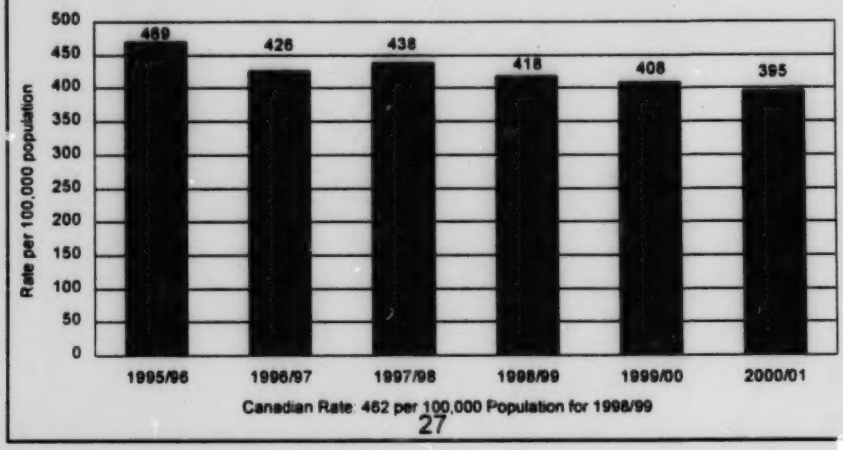
Crude Rates Per 100,000 (Female) Population
Nova Scotia - 1995/96 to 2000/01



26

HYSTERECTOMIES

Rates Per 100,000 Age-Standardized to the 1991 (Female) Canadian Population - Nova Scotia - 1995/96 to 2000/01

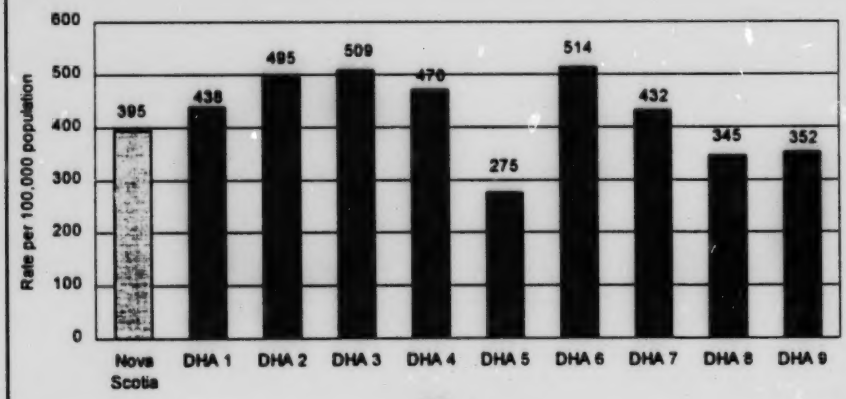


Canadian Rate: 462 per 100,000 Population for 1998/99

27

HYSTERECTOMIES

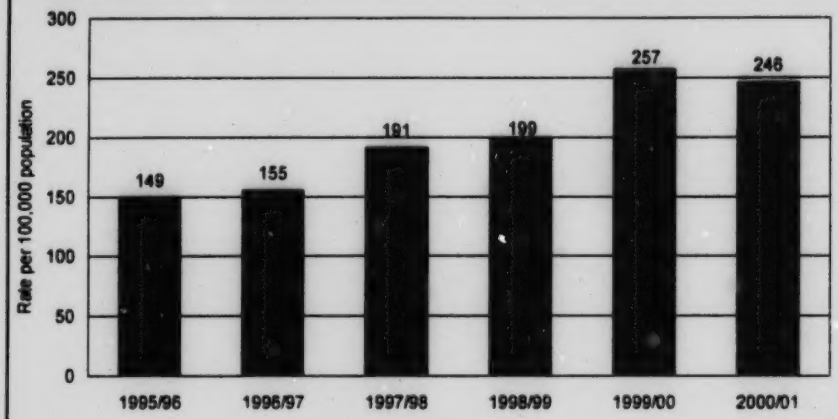
2000/01 Rates Per 100,000 Age-Standardized to the 1991 Canadian Population - by DHA of Residence



28

CARDIAC CATHETERIZATIONS

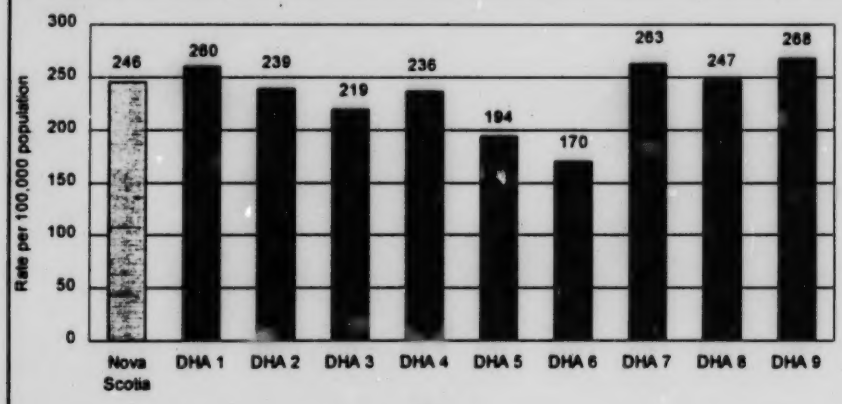
Rates Per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia - 1995/96 to 2000/01



29

CARDIAC CATHETERIZATIONS

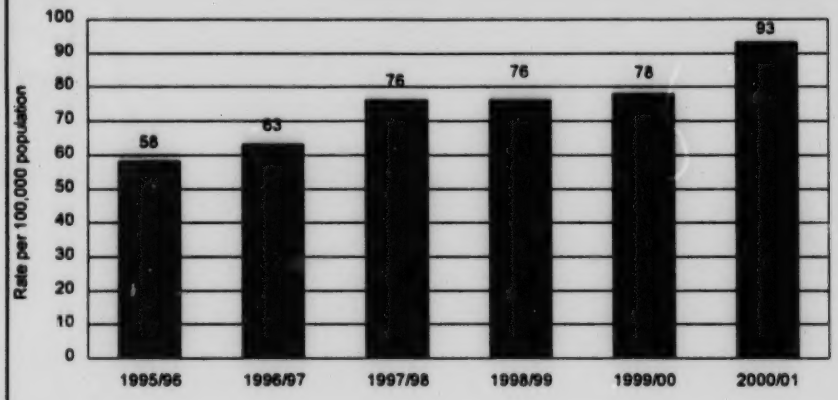
2000/01 Rates Per 100,000 Age-Standardized to the 1991 Canadian Population - by DHA of Residence



30

CORONARY ANGIOPLASTIES

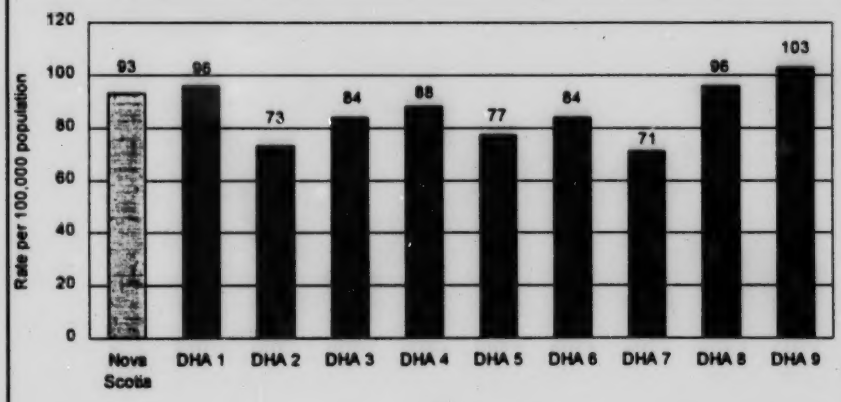
Rates Per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia - 1995/96 to 2000/01



31

CORONARY ANGIOPLASTIES

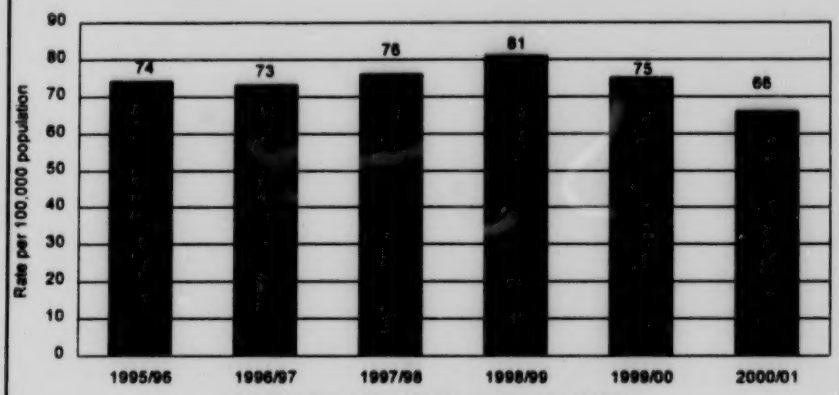
2000/01 Rates Per 100,000 Age-Standardized to the 1991 Canadian Population - by DHA of Residence



32

CORONARY ARTERY BYPASS GRAFT

Rates Per 100,000 Age-Standardized to the 1991 Canadian Population -
Nova Scotia - 1995/96 to 2000/01

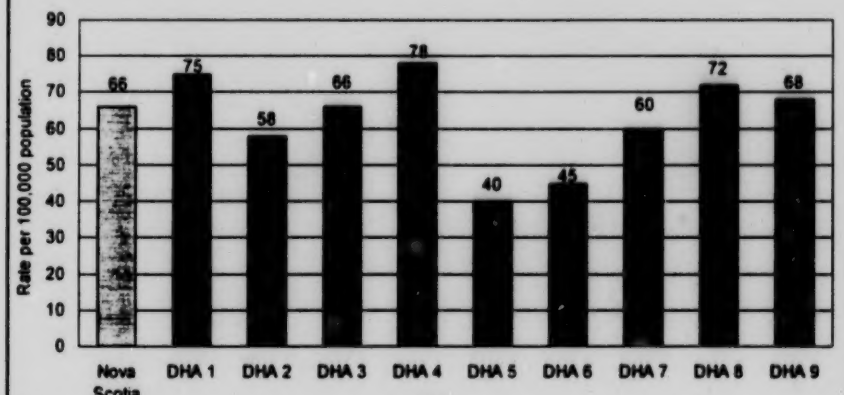


Canadian Rate: 96 per 100,000 population for 1998/99

33

CORONARY ARTERY BYPASS GRAFT

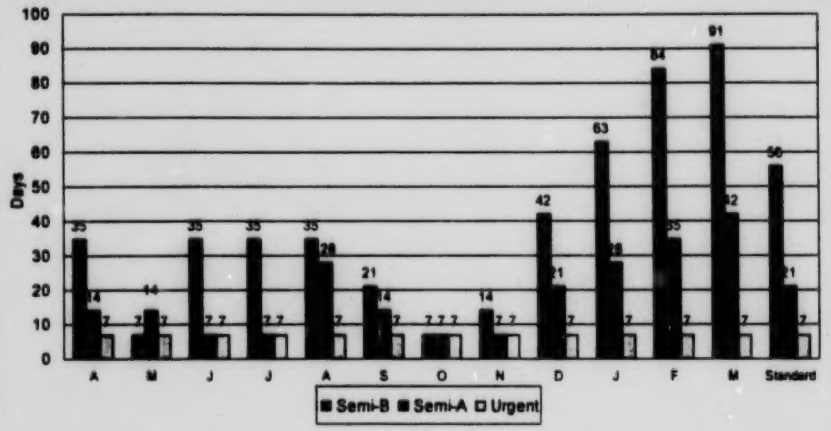
2000/01 Rates Per 100,000 Age-Standardized
to the 1991 Canadian Population - by DHA of Residence



34

CARDIOVASCULAR SURGERY WAIT TIMES (URGENT)

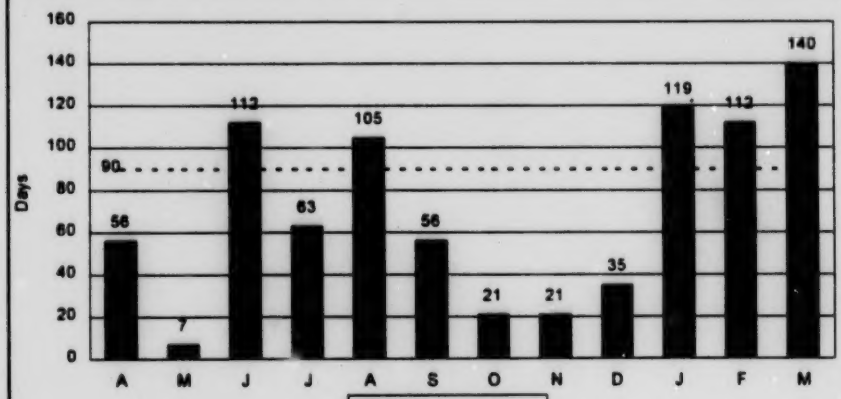
by Category and Month April 2000 to March 2001



35

CARDIOVASCULAR SURGERY WAIT TIMES (ELECTIVE)

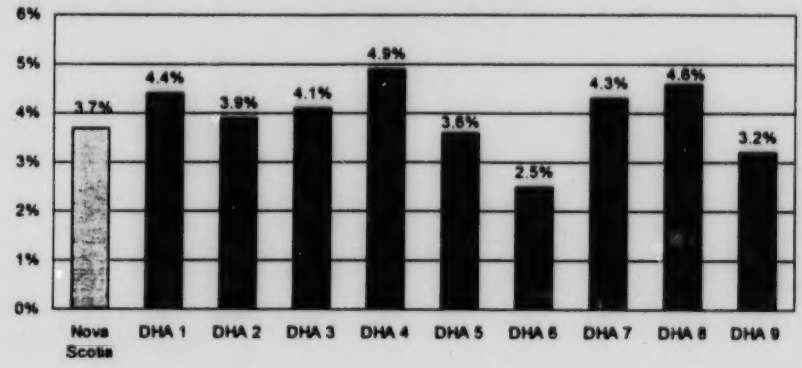
by Month April 2000 to March 2001



36

NON-ELECTIVE READMISSIONS TO THE SAME HOSPITAL WITHIN ONE WEEK OF DISCHARGE

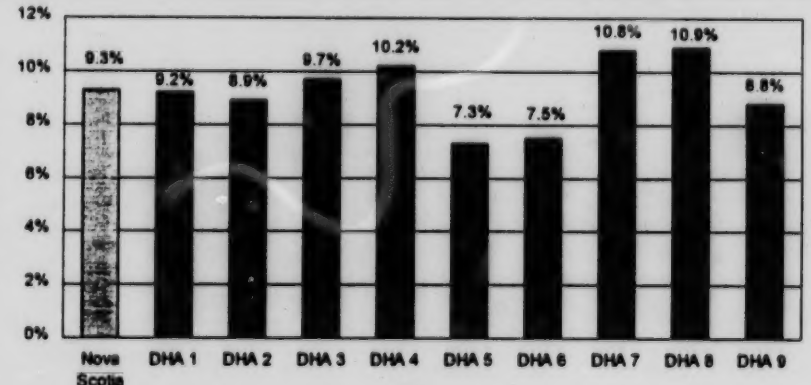
by DHA of Hospitalization - 2000/01



37

NON-ELECTIVE READMISSIONS TO THE SAME HOSPITAL WITHIN ONE MONTH OF DISCHARGE

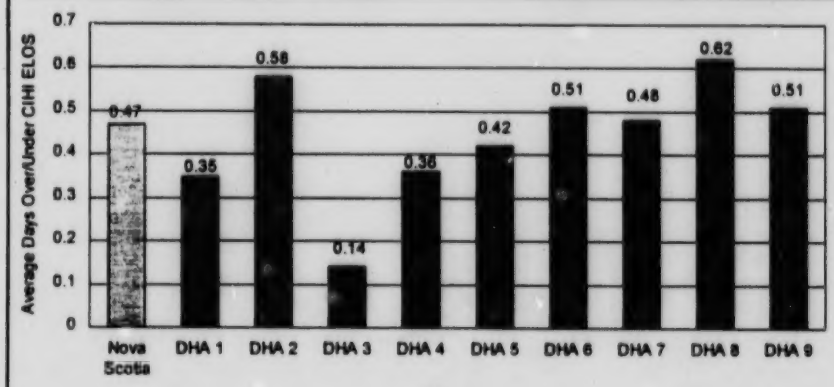
by DHA of Hospitalization - 2000/01



38

AVERAGE NUMBER OF DAYS OVER/UNDER CIHI EXPECTED LENGTH OF STAY (ELOS)

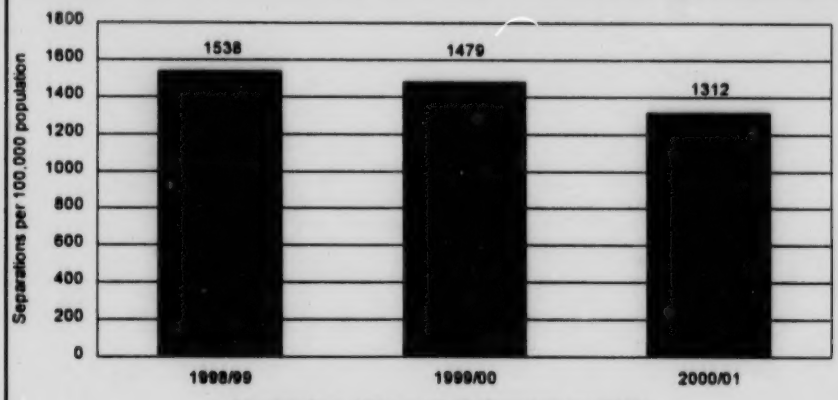
Nova Scotia - by DHA of Residence - 2000/01



39

PNEUMONIA/INFLUENZA

Rates Per 100,000 Age-Standardized to the 1991 Canadian Population (≥ 65 Years) - Nova Scotia - 1998/99 to 2000/01

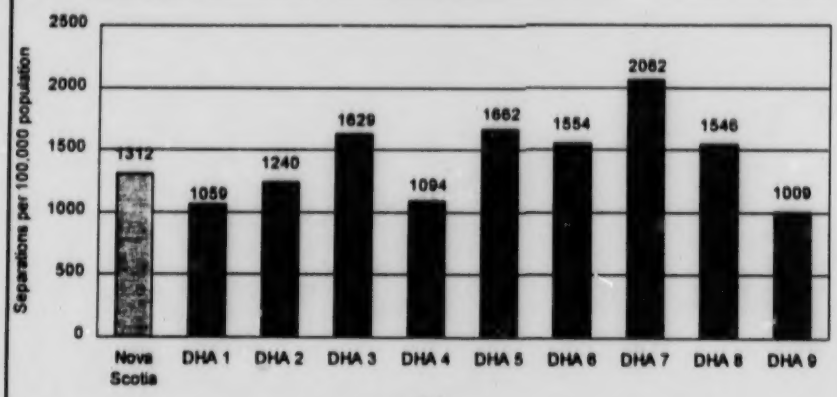


Canadian Rate: 1273 per 100,000 Population for 1998/99

40

PNEUMONIA/INFLUENZA

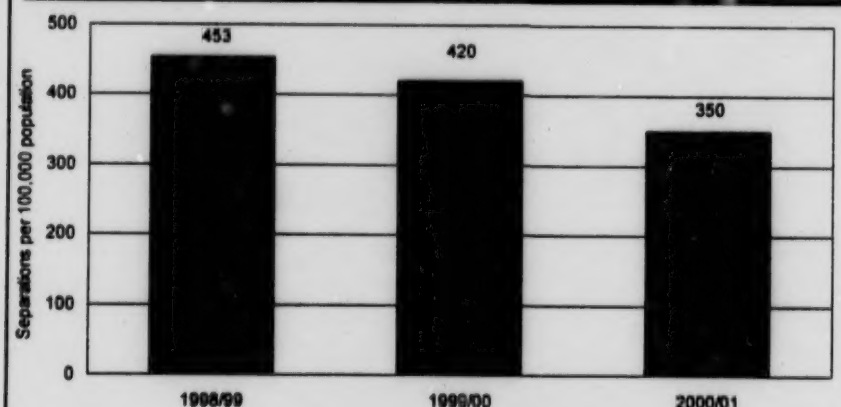
Rates Per 100,000 Age-Standardized to the 1991 Canadian Population (≥ 65 Years) - Nova Scotia 2000/01 by DHA of Residence



41

AMBULATORY CARE SENSITIVE CONDITIONS

Separations Per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia - 1998/99 to 2000/01

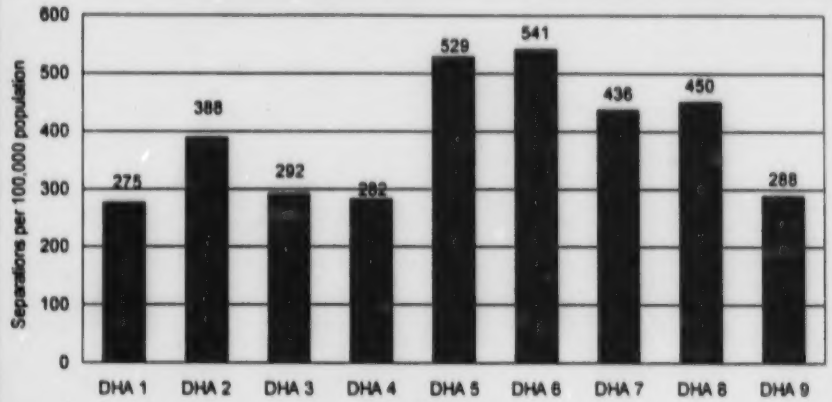


42

Canadian Rate 411 for 1998/99

AMBULATORY CARE SENSITIVE CONDITIONS

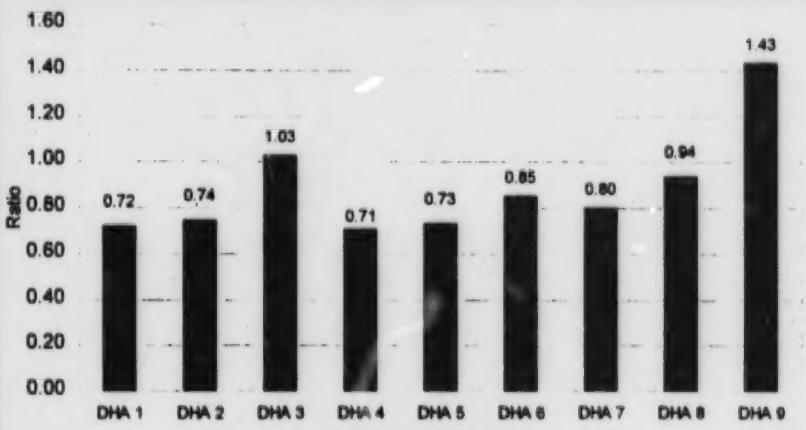
Separations Per 100,000 Age-Standardized to the 1991 Canadian Population - by DHA of Residence - Nova Scotia 2000/01



43

INFLOW/OUTFLOW RATIO

by District Health Authority 2000/01



44

MENTAL HEALTH PROGRAMS

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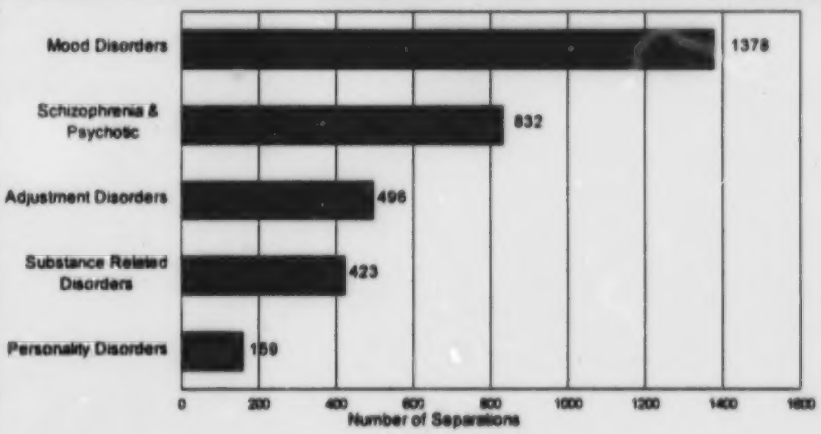
MENTAL HEALTH PROGRAMS

Inpatient Separations - Adults (≥ 19 Years) Nova Scotia
Excluding Forensic and Extended Care Units 2000/01



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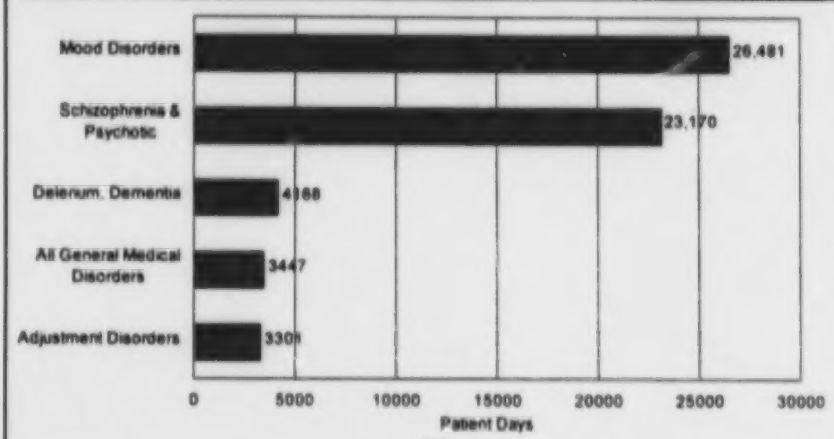
MENTAL HEALTH PROGRAMS

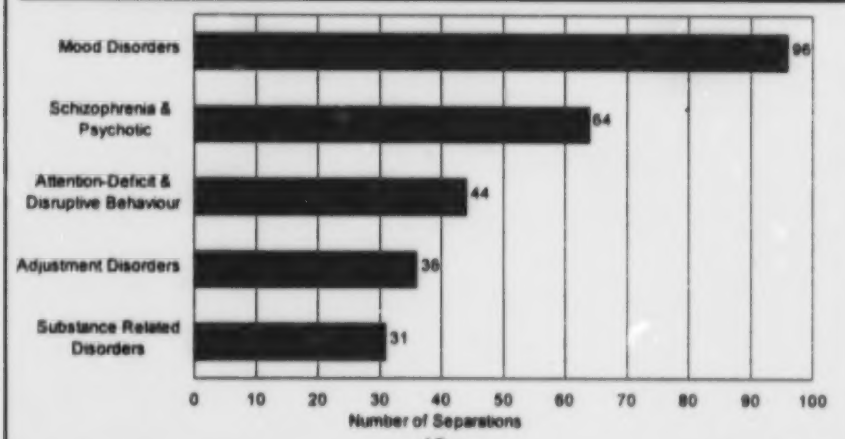
Patient Days - Adults (≥ 19 Years) Nova Scotia
Excluding Forensic and Extended Care Units 2000/01



47

MENTAL HEALTH PROGRAMS

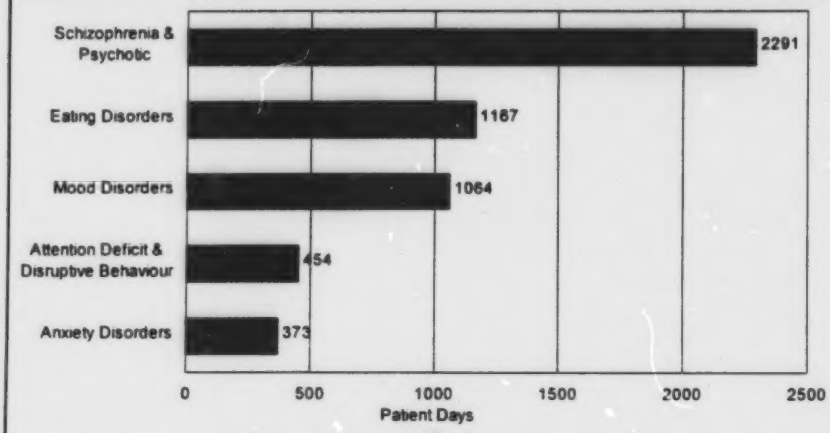
Inpatient Separations - Children (≤18 Years)
Nova Scotia - Excl. Forensic and Extended Care Units - 2000/01



48

MENTAL HEALTH PROGRAMS

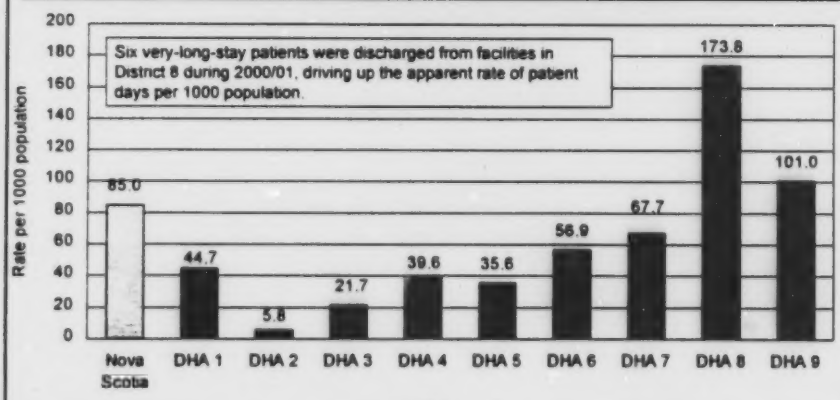
Patient Days - Children (≤18 Years) Nova Scotia - Excl. Forensic and Extended Care Units 2000/01



49

MENTAL HEALTH PROGRAMS - PATIENT DAYS PER 1000 POPULATION

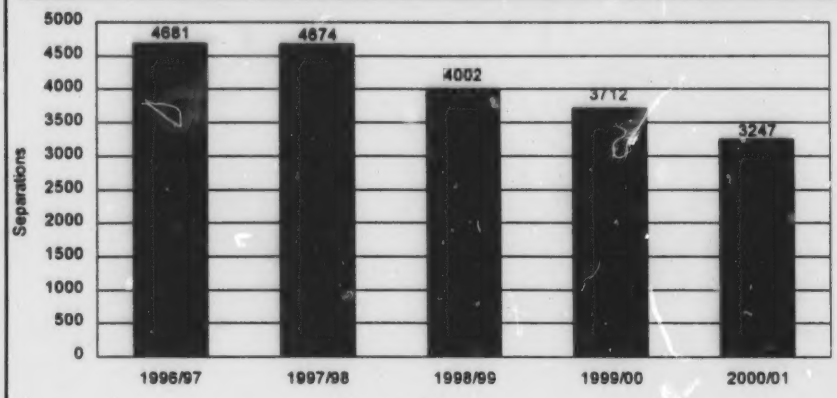
Acute Psychiatric Care by DHA of Residence
Crude Rates Per 1000 Population - 2000/01



50

MENTAL HEALTH PROGRAMS
INPATIENT SEPARATIONS

Acute Psychiatric Care - Adults (≥19 Years)
Nova Scotia - 1996/97 to 2000/01



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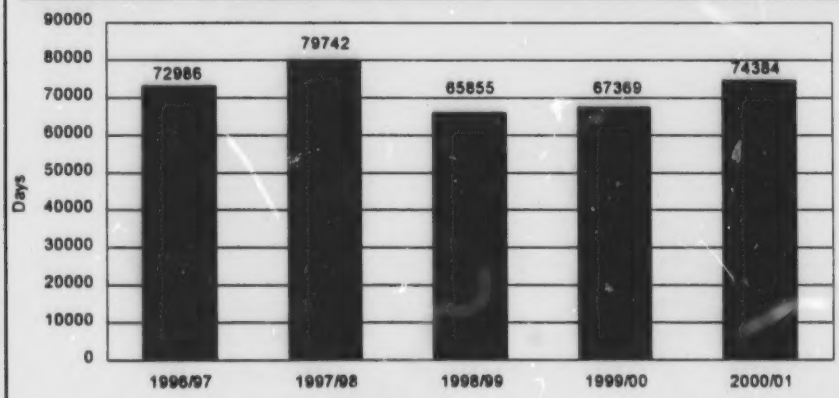
MENTAL HEALTH PROGRAMS
INPATIENT DAYS

Acute Psychiatric Care - Adults (≥19 Years)
Nova Scotia - 1996/97 to 2000/01



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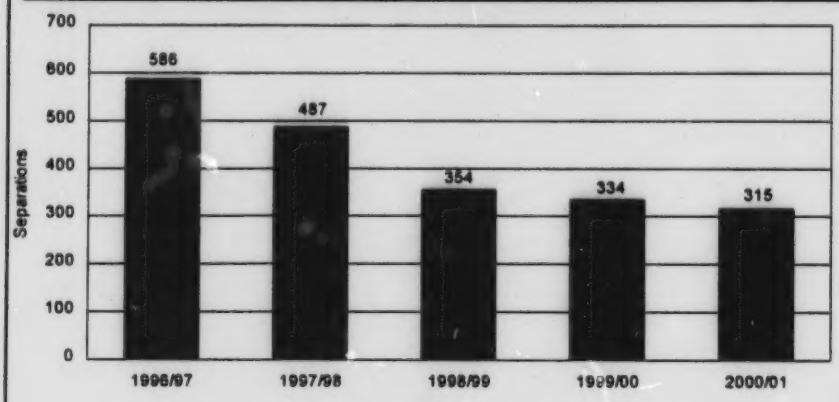
MENTAL HEALTH PROGRAMS
INPATIENT SEPARATIONS

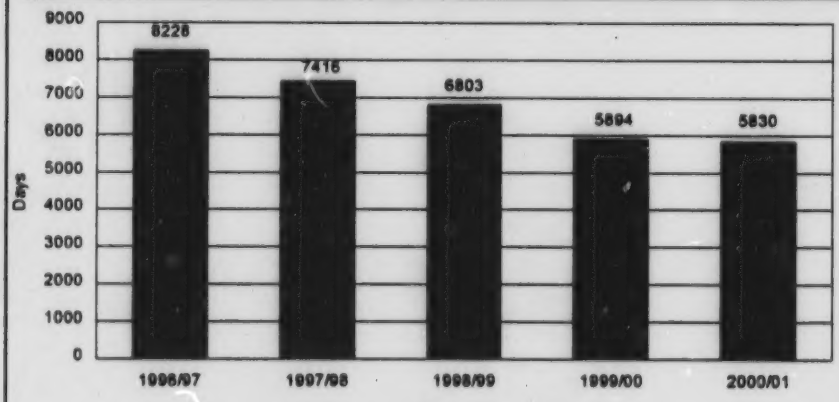
Acute Psychiatric Care - Children (≤18 Years)
Nova Scotia - 1996/97 to 2000/01



53

MENTAL HEALTH PROGRAMS
INPATIENT DAYS

Acute Psychiatric Care - Children (≤18 Years)
Nova Scotia - 1996/97 to 2000/01



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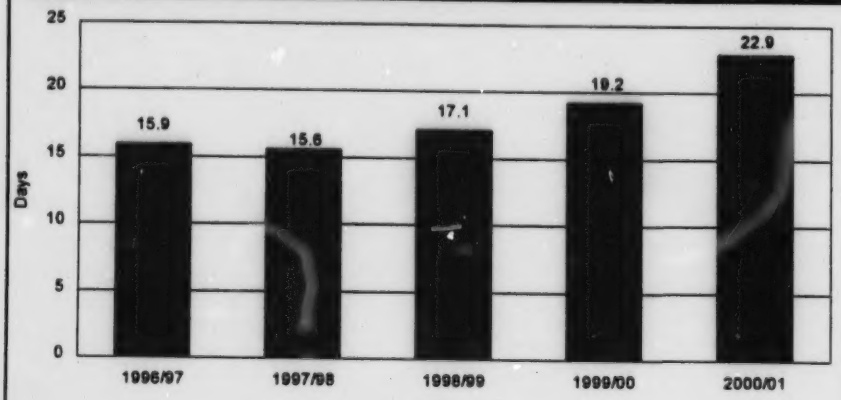
MENTAL HEALTH PROGRAMS
AVERAGE LENGTH OF STAY

Acute Psychiatric Care - Adults (≥19 Years)
Nova Scotia - 1996/97 to 2000/01



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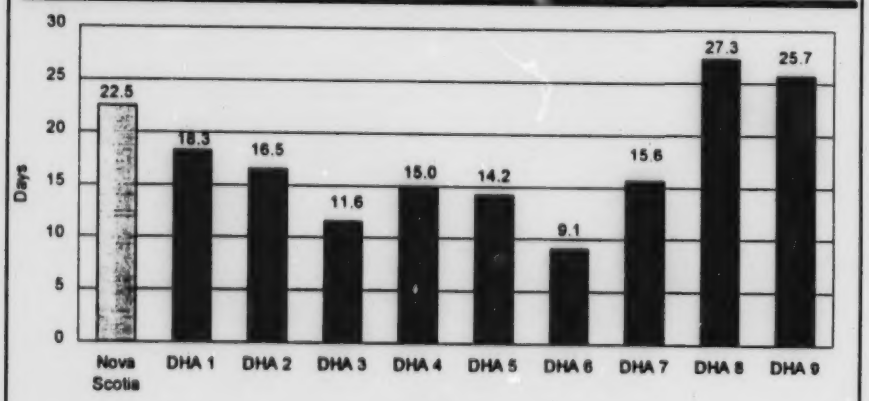
MENTAL HEALTH PROGRAMS
AVERAGE LENGTH OF STAY

Acute Psychiatric Care - by DHA of Residence - 2000/01



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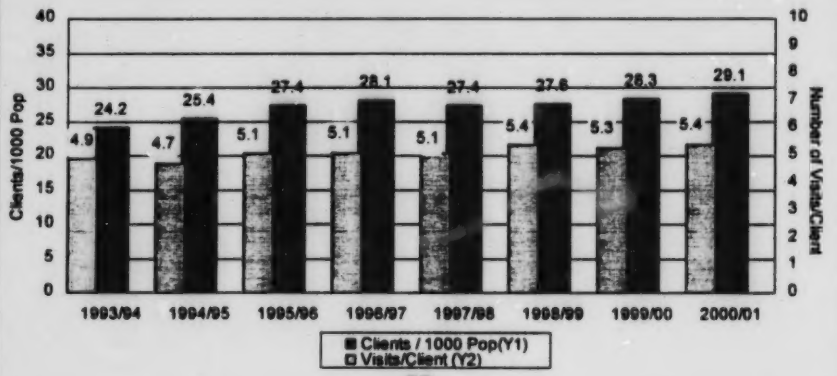
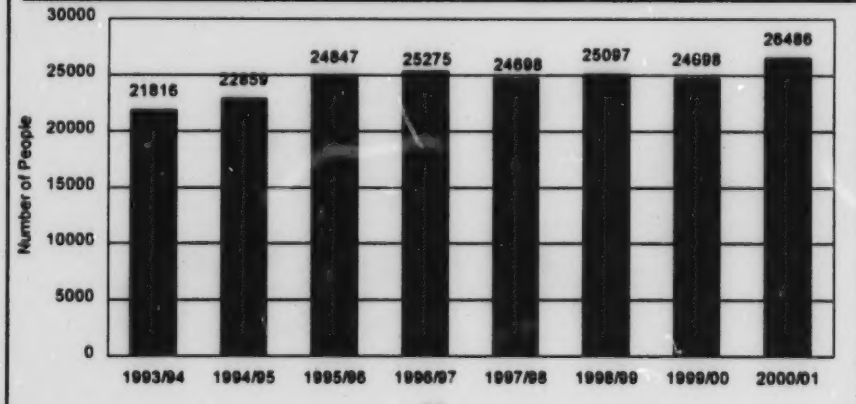
MENTAL HEALTH PROGRAMS
AMBULATORY CARE

Average MIS Visits Per Client and Active MIS Clients Per 1000 Population - 1993/94 to 2000/01

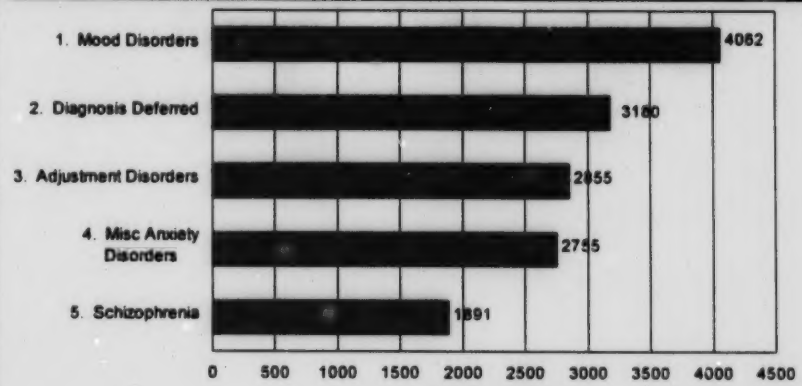


MENTAL HEALTH PROGRAMS
AMBULATORY CARE

Number of People Served - Mental Health Outpatient Information System (MHOIS) - Unique Clients 1993/94 to 2000/01



MENTAL HEALTH PROGRAMS
TOP DIAGNOSES
Outpatient Clinics - Adults (≥18 Years) 2000/01



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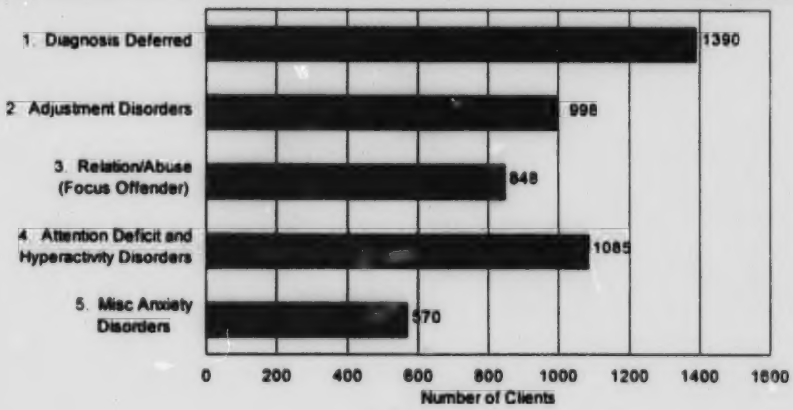
MENTAL HEALTH PROGRAMS
TOP DIAGNOSES
Outpatient Clinics - Youth (<18 Years) 2000/01



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ADDICTION SERVICES PROGRAMS

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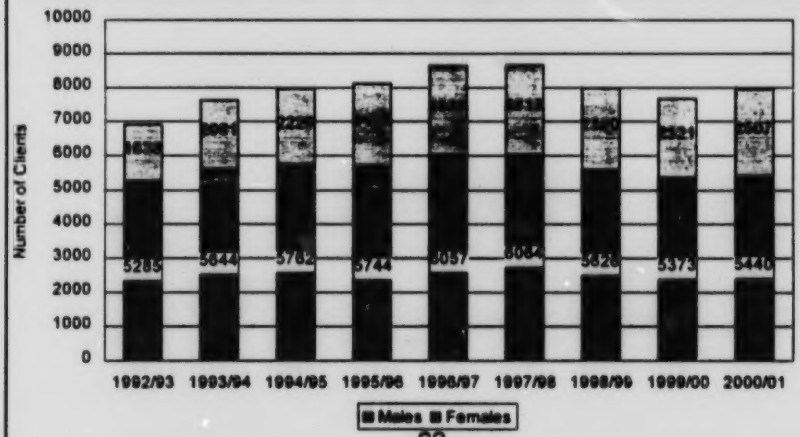
ADDICTION SERVICES PROGRAMS

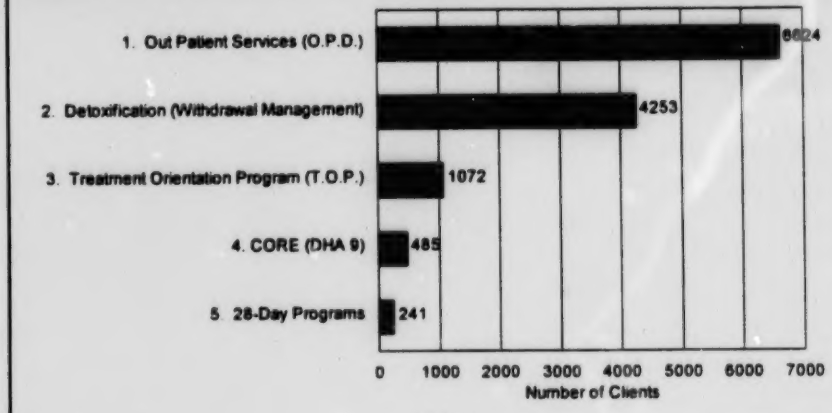
Number of Clients Served - By Gender - 1992/93 to 2000/01



62

ADDICTION SERVICES PROGRAMS

Service Utilization Breakdown - Outpatient and Inpatient Services 2000/01



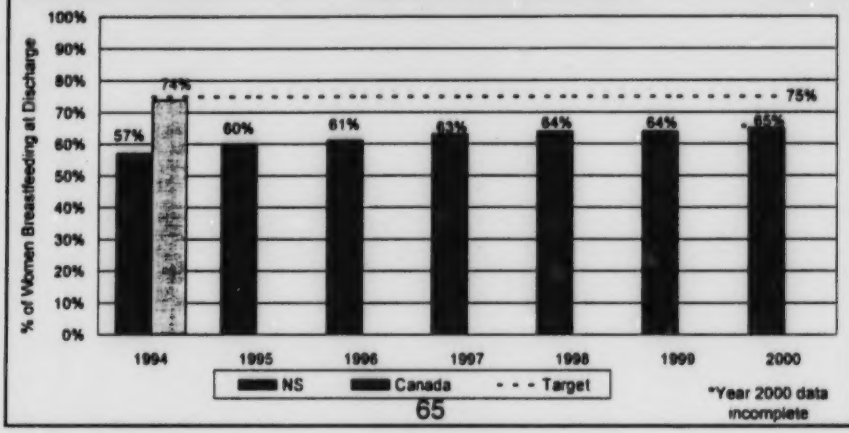
63

PUBLIC HEALTH

64

BREAST FEEDING RATES - NOVA SCOTIA - 1994 TO 2000 & CANADA 1994

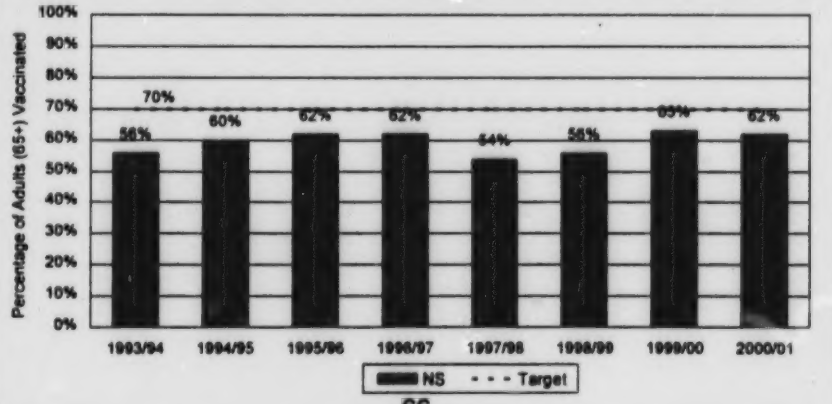
The Rate Is Based on the Number of Women Breastfeeding at Hospital Discharge



65

INFLUENZA VACCINATION RATES - NOVA SCOTIA - 1993/94 TO 2000

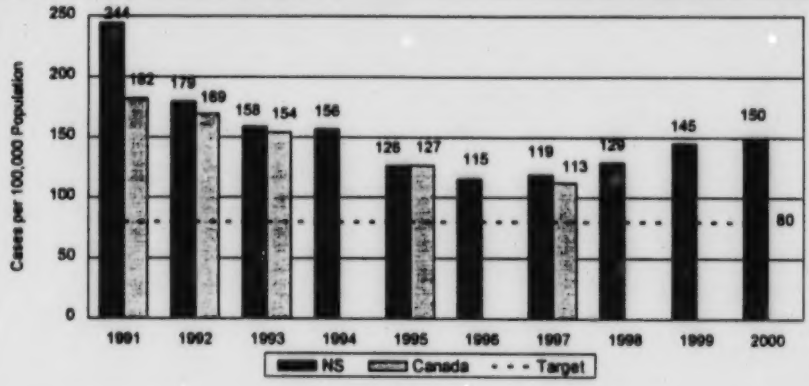
Percentage of Adults Vaccinated (≥ 65 Years)



66

CHLAMYDIA INCIDENCE PER 100,000 POPULATION

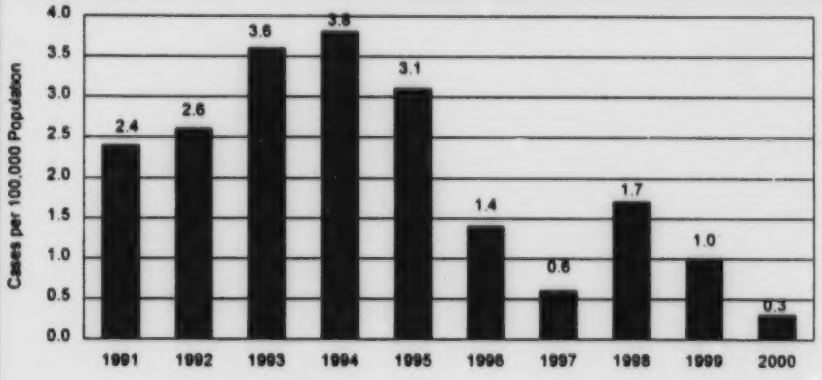
Nova Scotia - 1991 to 2000; Canada 1991 to 1997



67

AIDS INCIDENCE PER 100,000 POPULATION

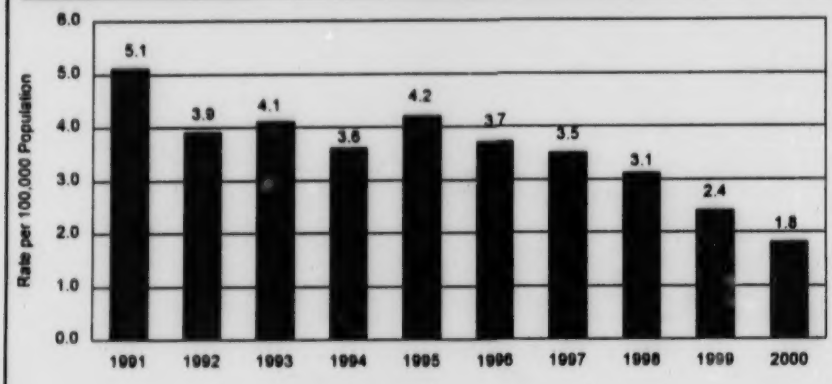
Nova Scotia - 1991 to 2000



68

HIV INCIDENCE
PER 100,000 POPULATION

Nova Scotia - 1991 to 2000



69

TOBACCO CONTROL UNIT

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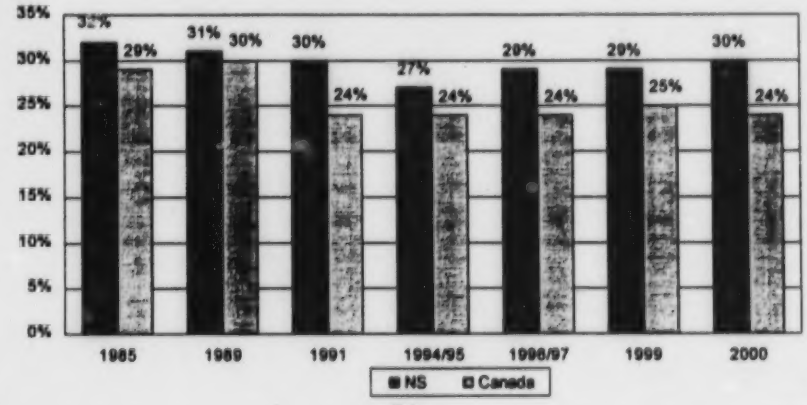
SMOKING RATES

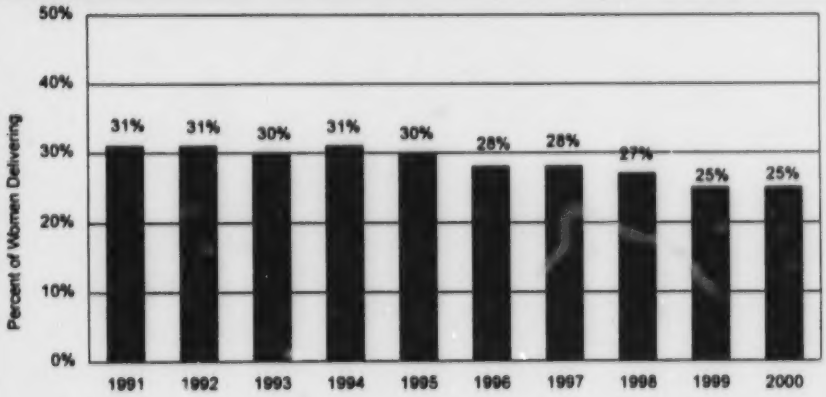
Ages ≥ 15 Years - Nova Scotia and Canada



71

SMOKING RATES

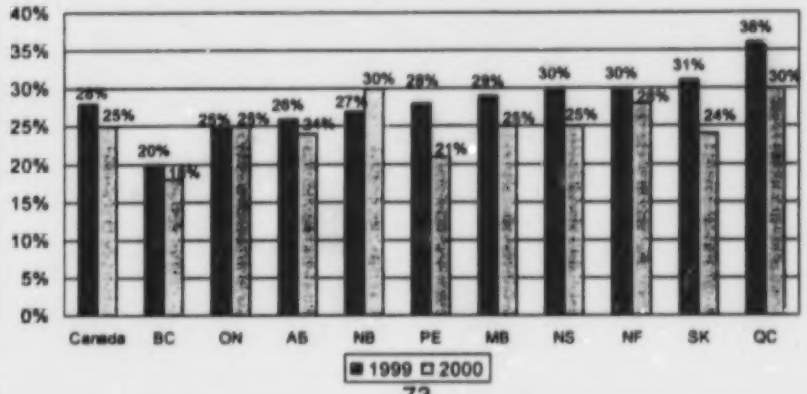
Nova Scotia Women Who Smoked During Pregnancy As Reported Upon Hospital Admission - 1991 to 2000



72

SMOKING RATES

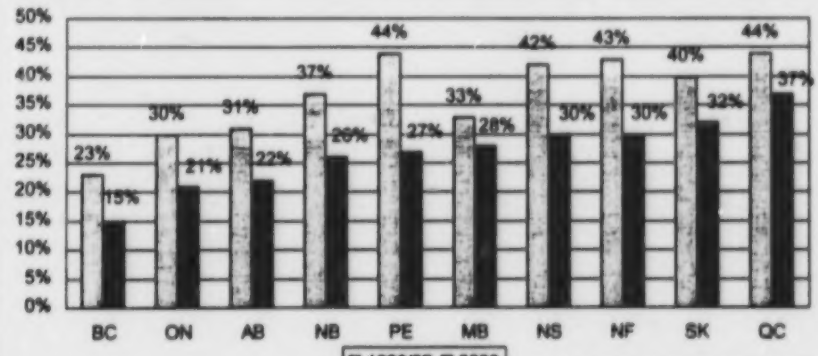
Youth Smoking - Age 15 To 19 for 1999 & 2000
by Province



73

ENVIRONMENTAL TOBACCO SMOKE

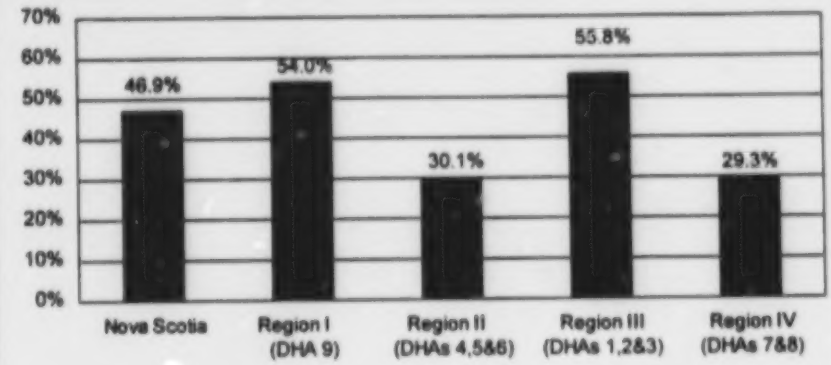
Children's Exposure to Tobacco Smoke at Home
Percentage of Homes With Children Age 0 -11 Where Someone Smokes Regularly, by Provinces & Canada*, 1996/97 and 2000



74

TOBACCO CONTROL UNIT

Compliance Rates By Region/DHA
Nova Scotia Retailers - 2000/01



75

HOME CARE NOVA SCOTIA

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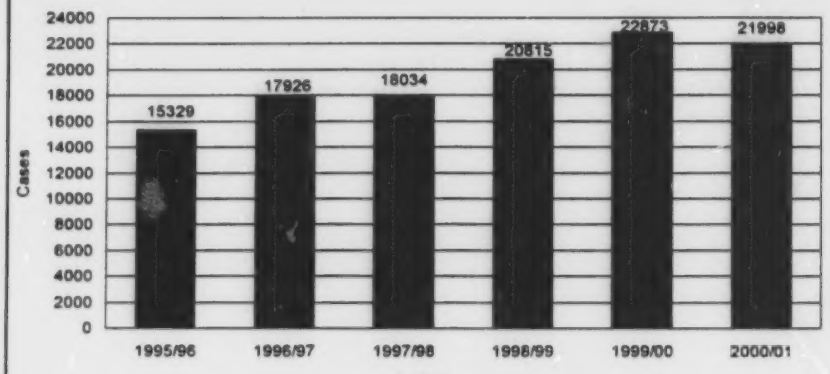
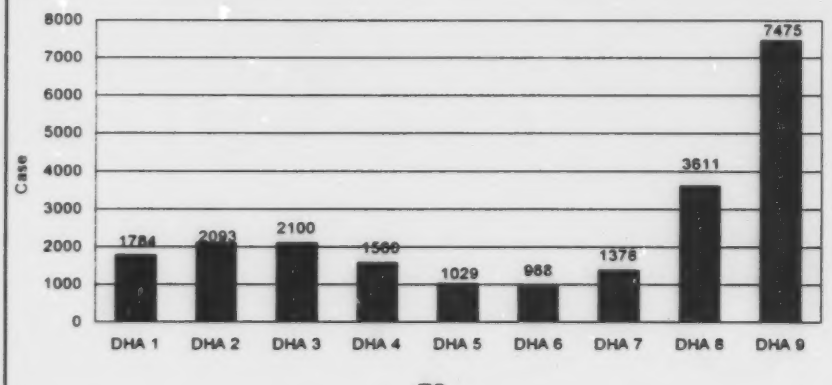
HOME CARE NOVA SCOTIA
ANNUAL CASELOAD
Nova Scotia - 1995/96 to 2000/01



77

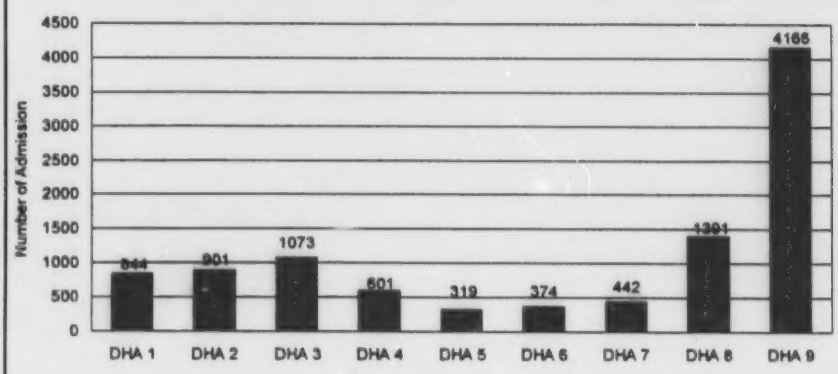
HOME CARE NOVA SCOTIA
ANNUAL CASELOAD
Nova Scotia - By DHA of Residence - 2000/01



78

HOME CARE NOVA SCOTIA

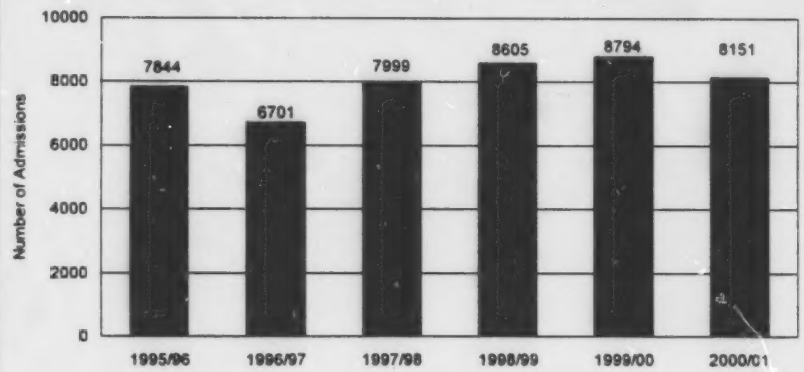
Number of Admissions by DHA of Residence - 2000/01



79

HOME CARE NOVA SCOTIA

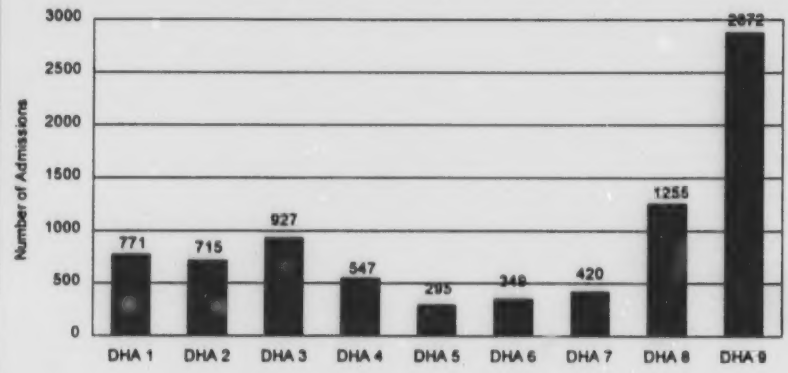
Chronic Home Care Services Admissions
Nova Scotia - 1995/96 to 2000/01



80

HOME CARE NOVA SCOTIA

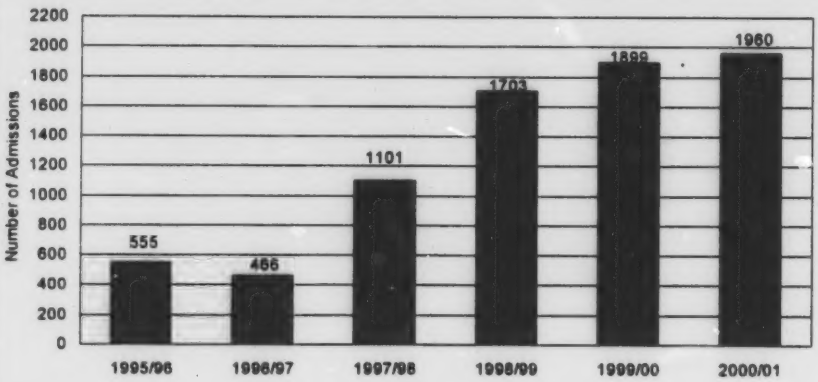
Chronic Home Care Services Admissions
by DHA of Residence - 2000/01



81

HOME CARE NOVA SCOTIA

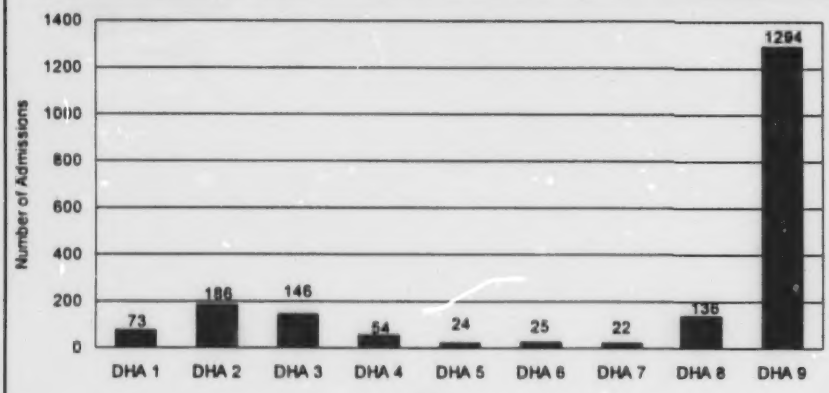
Acute Home Care Services Admissions
Nova Scotia -1995/96 to 2000/01



82

HOME CARE NOVA SCOTIA

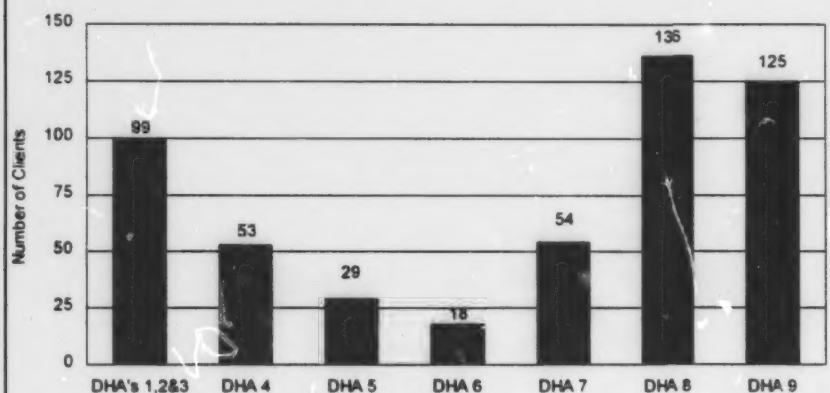
Acute Home Care Services Admissions
by DHA of Residence - 2000/01



83

HOME CARE NOVA SCOTIA

Number of Clients Receiving Home Oxygen (New Starts)
by Region/DHA of Residence 2000/01



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EMERGENCY HEALTH SERVICES

GROUND AMBULANCE

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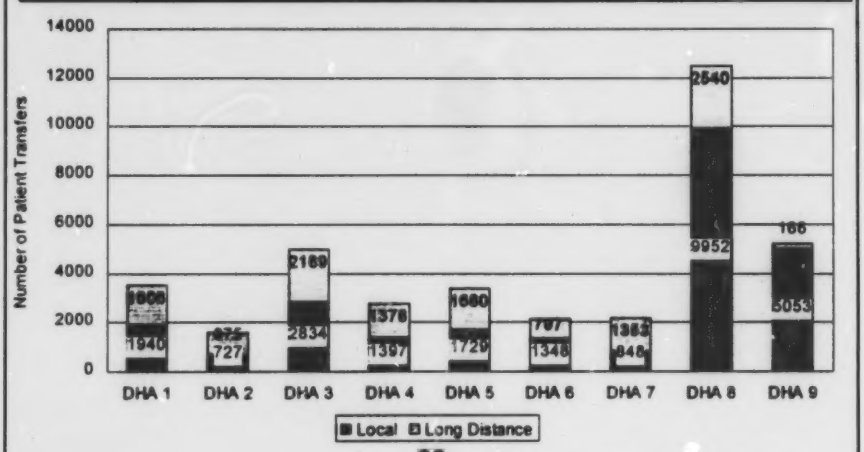
EMERGENCY HEALTH SERVICES

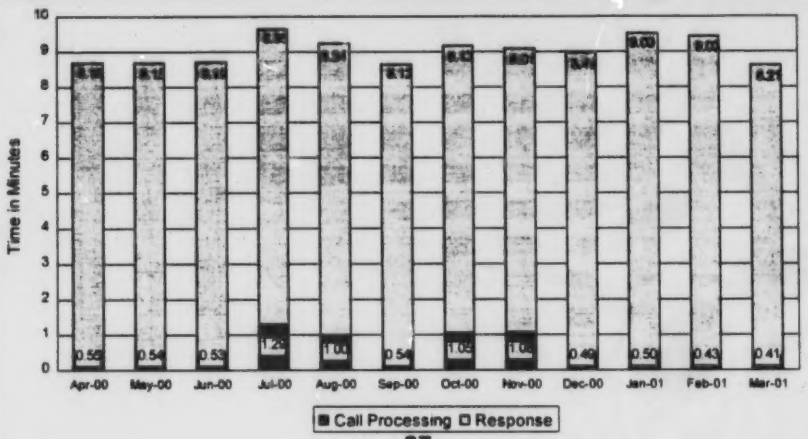
Ground Ambulance - Local and Long Distance Transfer Volume by DHA
2000/01



86

EMERGENCY HEALTH SERVICES

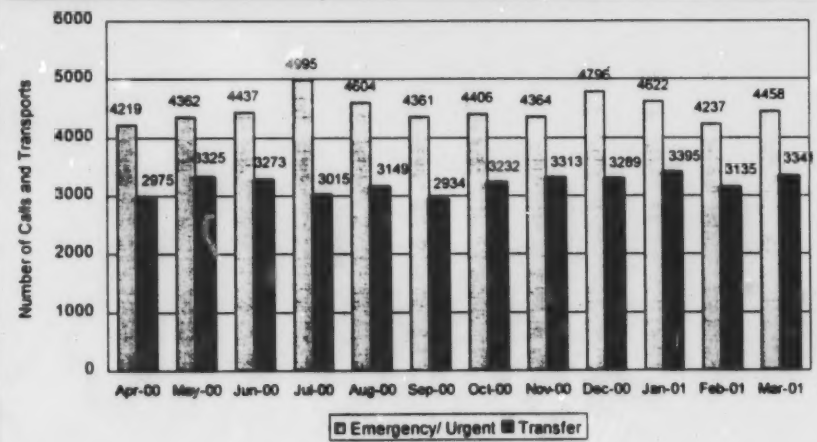
Ground Ambulance - Average Emergency Call Processing and Response Times 2000/01



87

EMERGENCY HEALTH SERVICES

Ground Ambulance - Number of Calls and Non-Emergency Transports 2000/2001



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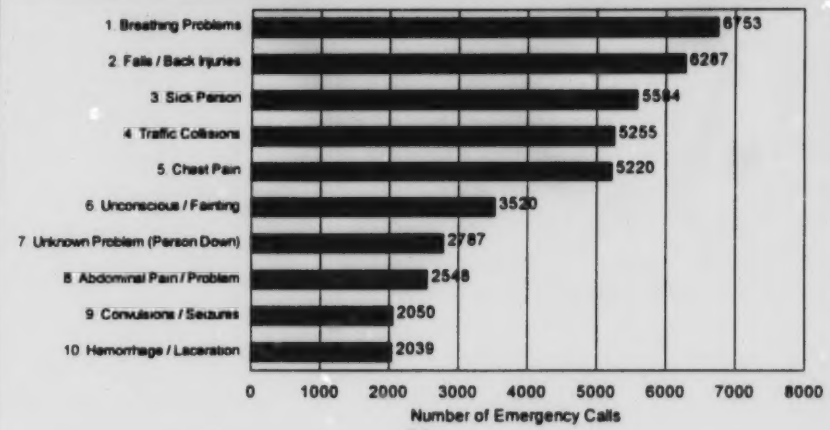
EMERGENCY HEALTH SERVICES

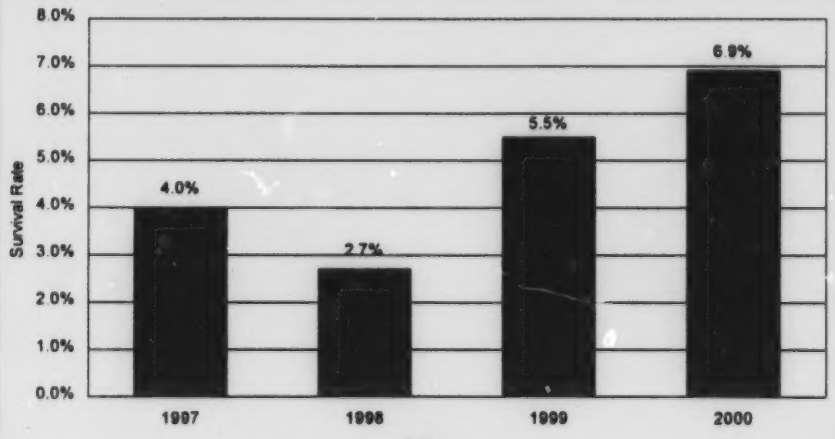
Ground Ambulance - Emergency Calls
'Top Ten' Chief Complaints - 2000/01



89

EMERGENCY HEALTH SERVICES

Ground Ambulance - Survival Rates
for Out of Hospital Cardiac Arrests 1997 - 2000



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EMERGENCY HEALTH SERVICES

EHS LIFEFLIGHT (AIR AMBULANCE)

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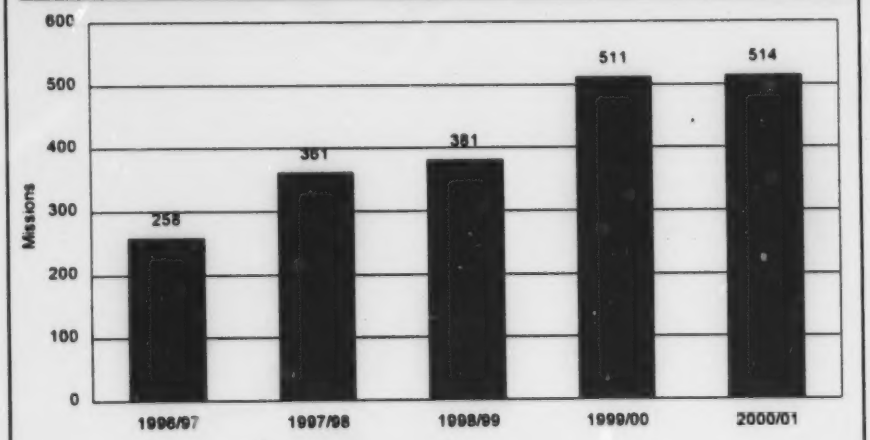
EMERGENCY HEALTH SERVICES

EHS LifeFlight (Air Ambulance)
Missions by Fiscal Year 1996/97 to 2000/01



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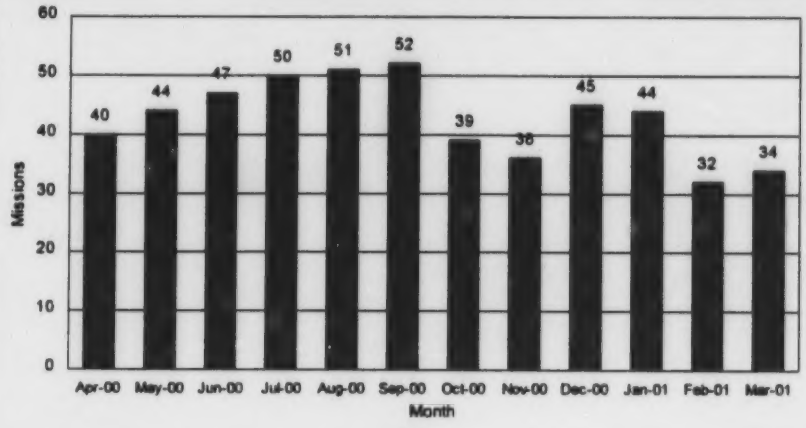
EMERGENCY HEALTH SERVICES

EHS LifeFlight (Air Ambulance)
Missions by Month 2000/2001



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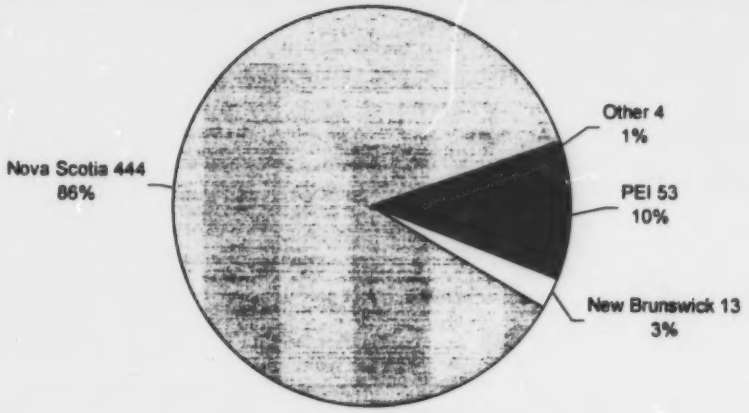
EMERGENCY HEALTH SERVICES

EHS LifeFlight (Air Ambulance)
Mission Locations During 2000/01



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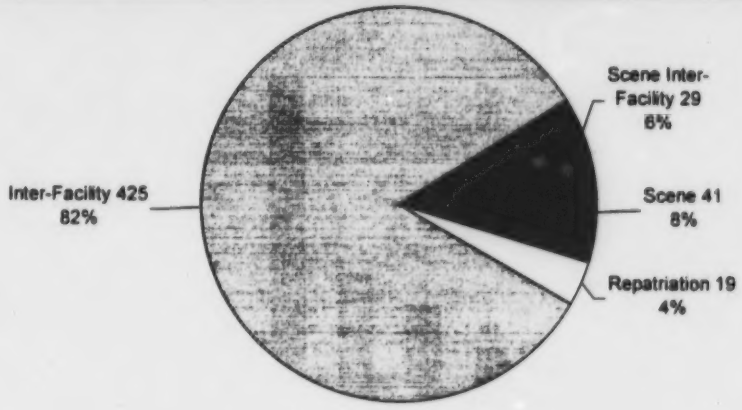
EMERGENCY HEALTH SERVICES

EHS LifeFlight (Air Ambulance) 1999/00
Missions By Response Type



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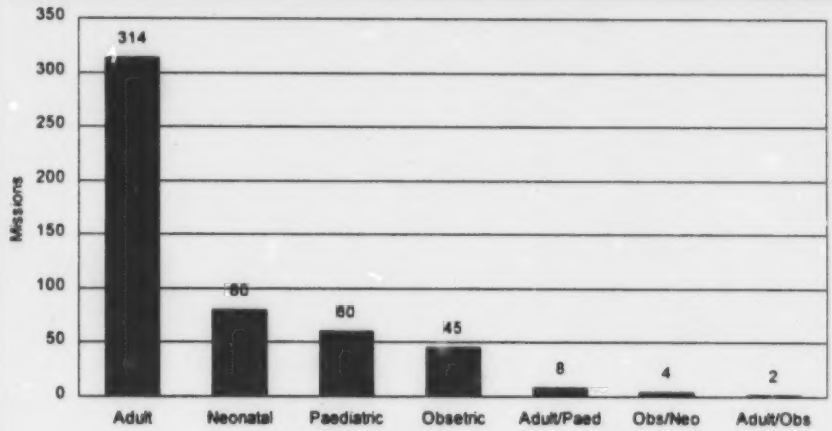
EMERGENCY HEALTH SERVICES

EHS LifeFlight (Air Ambulance)
Missions By Patient Age 2000/01



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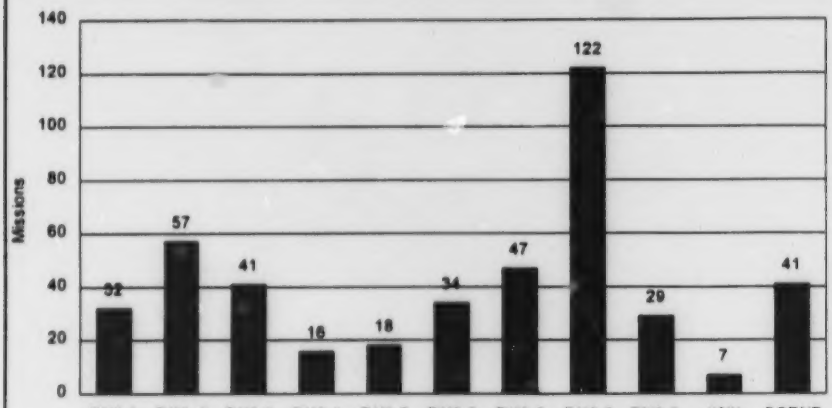
EMERGENCY HEALTH SERVICES

EHS LifeFlight (Air Ambulance)
Missions by DHA - 2000/01



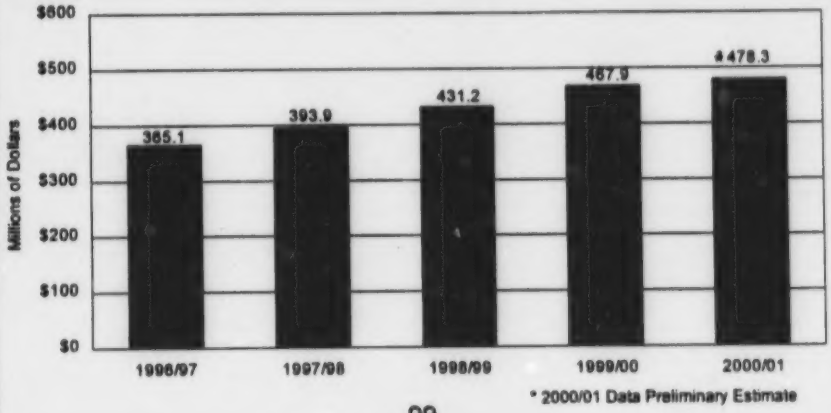
SERVICE EXPENDITURES

MEDICARE, PHARMACARE
AND CHILDREN'S ORAL HEALTH

Hospital and DHA Expenditure Data will be Available in the 2001/2002 Annual Statistical Report

EXPENDITURES FOR INSURED SERVICES

1996/97 to 2000/01 - Excludes Administrative Expenses



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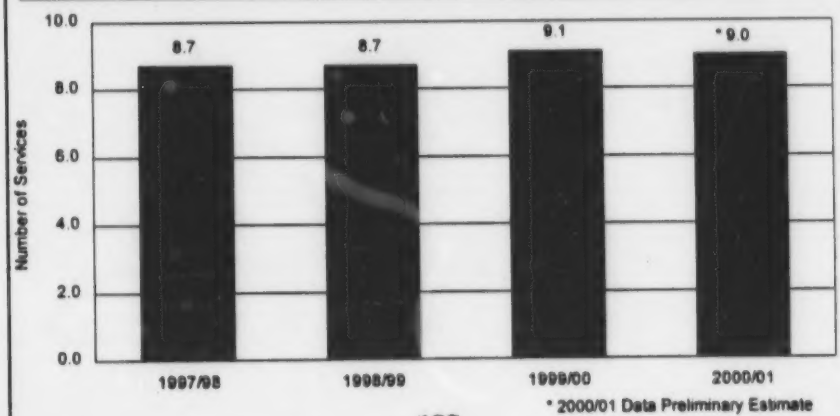
MEDICARE - NUMBER OF PHYSICIAN SERVICES PER BENEFICIARY

1997/98 to 2000/01



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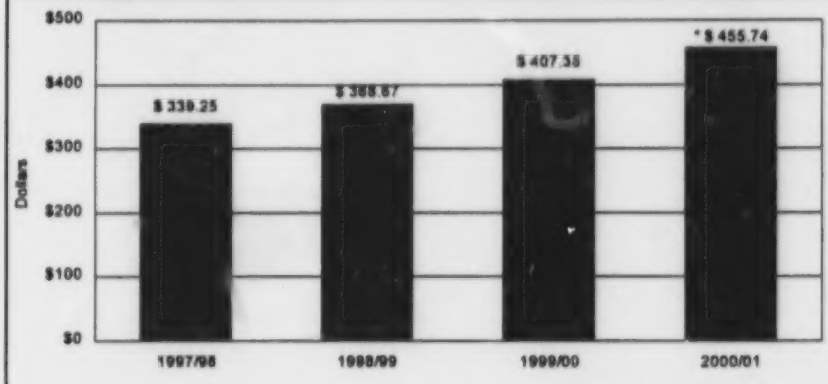
MEDICARE - PHYSICIAN SERVICES EXPENDITURES PER BENEFICIARY

1997/98 to 2000/01

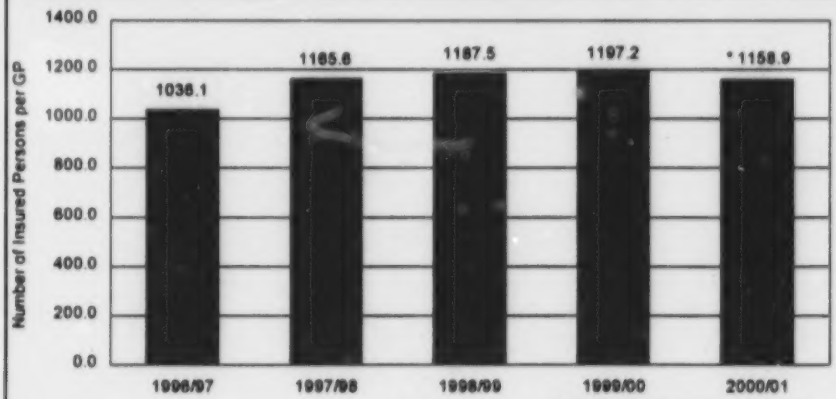


* 2000/01 Data Preliminary Estimate

101

MEDICARE - POPULATION PER GENERAL PRACTITIONER (GP)

Fee-for-Service Only - Total Number of Insured Population Per General Practitioner in Nova Scotia - 1996/97 to 2000/01

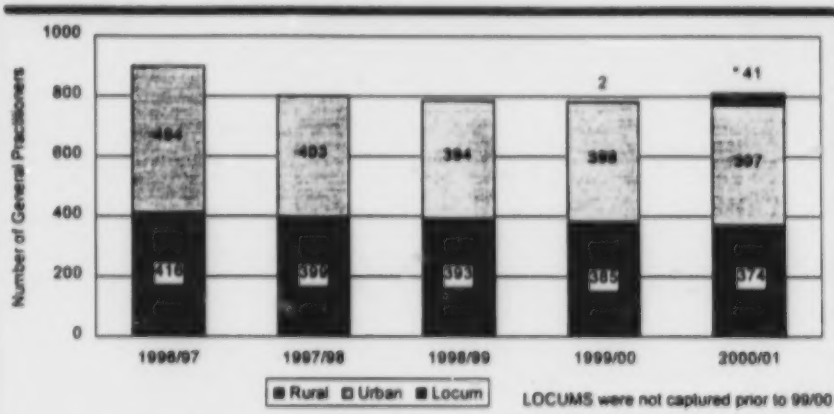


* 2000/01 Data Preliminary Estimate

102

MEDICARE - NUMBER OF GENERAL PRACTITIONERS (GP's)

Fee-for-Service Only - By Location: Urban, Rural & Total -
Nova Scotia 1996/97 to 2000/01

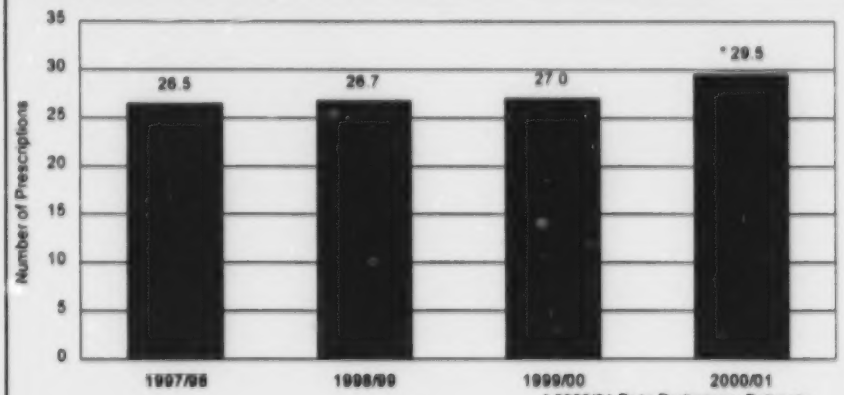


LOCUMS were not captured prior to 99/00

* 2000/01 Data Preliminary Estimate

PHARMACARE - NUMBER OF PRESCRIPTIONS PER BENEFICIARY

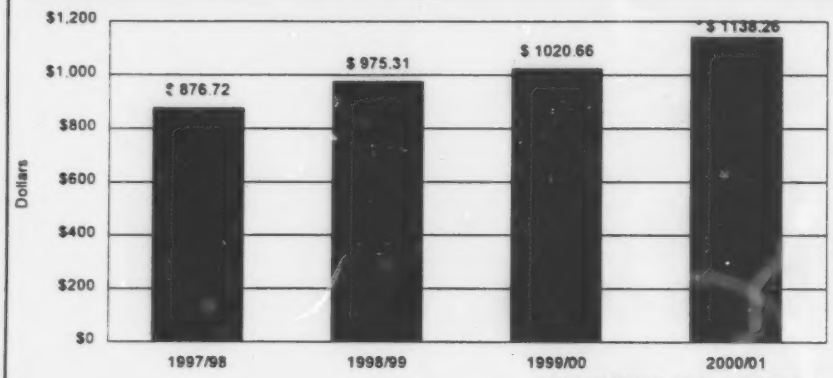
Nova Scotia 1997/98 To 2000/01



* 2000/01 Data Preliminary Estimate

MEDICARE - AMOUNT PAID FOR PRESCRIPTIONS PER BENEFICIARY

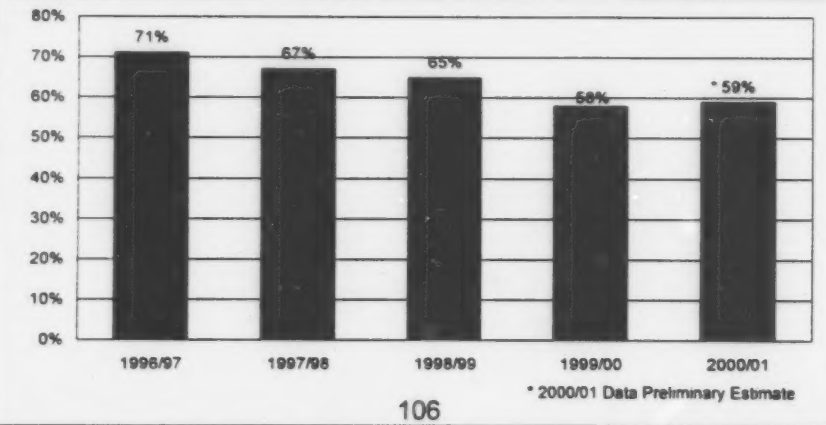
Nova Scotia 1997/98 to 2000/01



105

CHILDREN'S ORAL HEALTH - % OF CHILDREN RECEIVING ANNUAL DENTAL CHECKUPS

Ages 3 to 9 Years - 1996/97 to 2000/01



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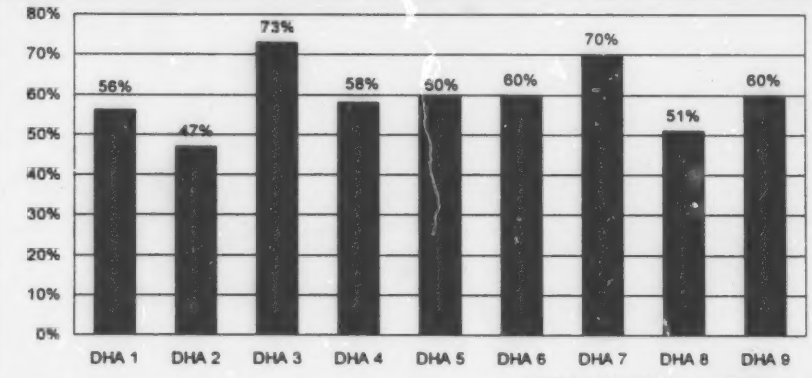
CHILDREN'S ORAL HEALTH - % OF CHILDREN RECEIVING ANNUAL DENTAL CHECK-UPS

Ages 3 to 9 Years by DHA of Residence - * 2000/01



* 2000/01 Data Preliminary Estimate

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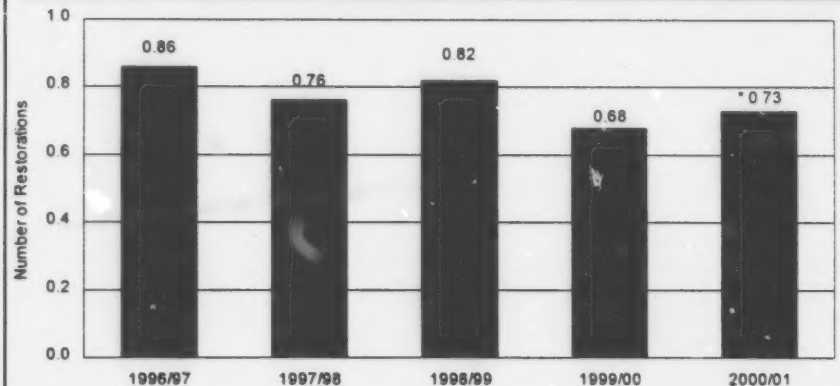
CHILDREN'S ORAL HEALTH - AVERAGE NUMBER OF DENTAL RESTORATIONS PER INSURED

Ages 3 to 9 - 1996/97 TO 2000/01



* 2000/01 Data Preliminary Estimate

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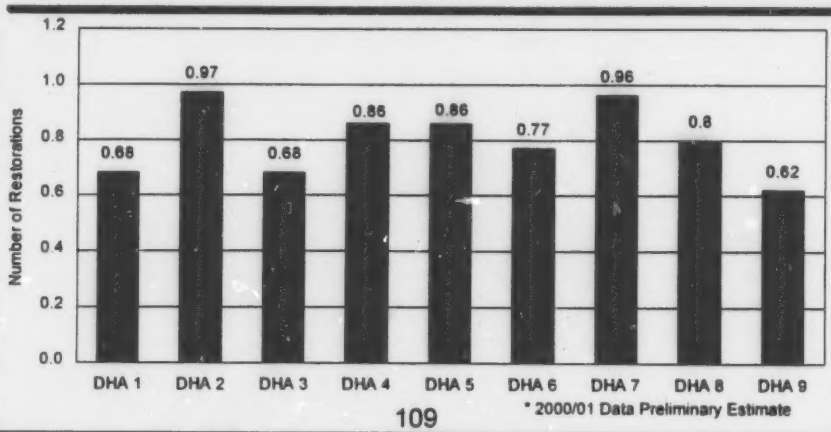
CHILDREN'S ORAL HEALTH - AVERAGE NUMBER OF DENTAL RESTORATIONS PER INSURED

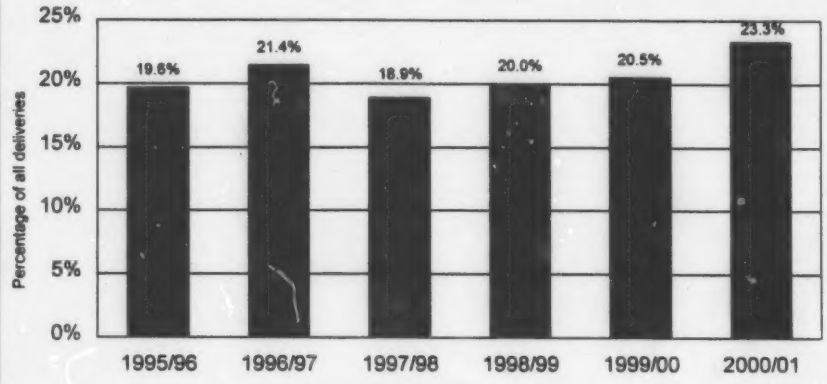
Ages 3 to 9 - by DHA of Residence - * 2000/01



WOMEN'S HEALTH

CAESAREAN SECTION RATE

Nova Scotia - 1995/96 to 2000/01

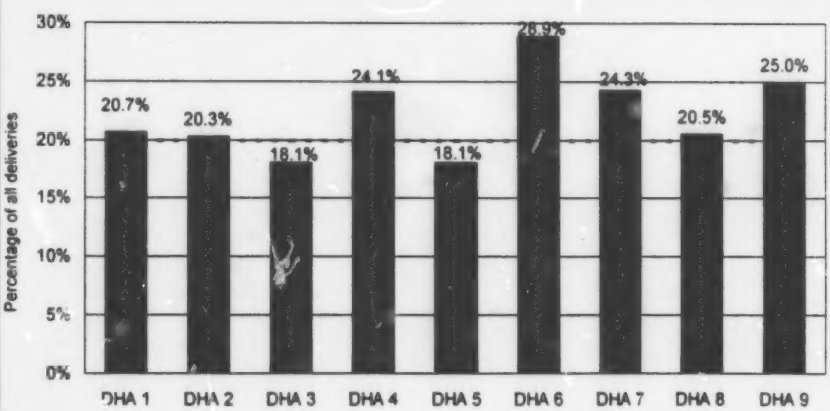


*Canadian Rate: 19.2 % in 1998/99

111

CAESAREAN SECTION RATE

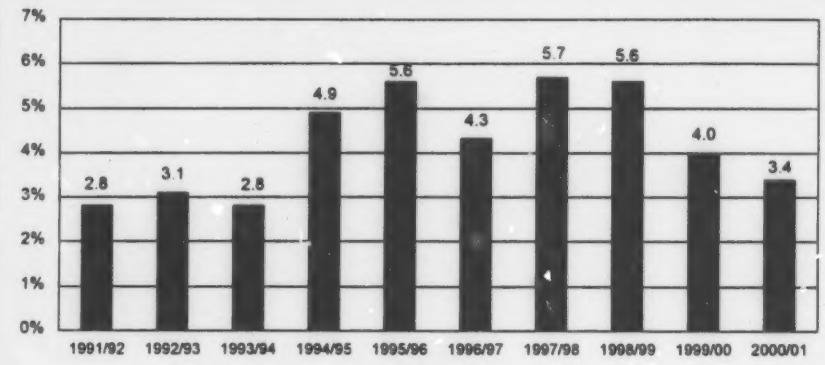
by DHA of Hospitalization - 2000/01



112

MAMMOGRAPHY SCREENING

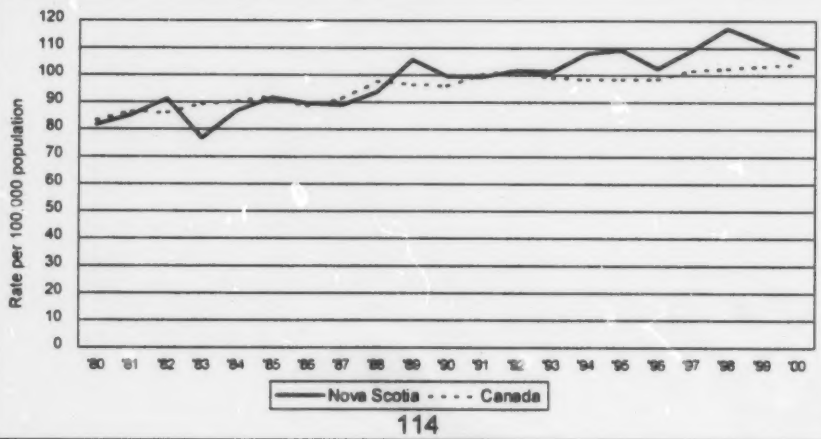
Percentage of Women Screened for the First Time
(Aged 50 to 69 Years)
Nova Scotia - 1991/92 to 2000/01



113

BREAST CANCER INCIDENCE RATES

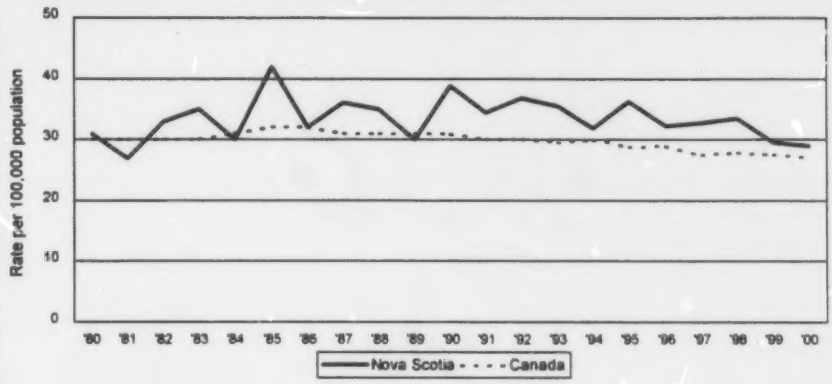
Rates Per 100,000 Age-Standardized to the 1991 Canadian Population
(Female) - Nova Scotia & Canada 1980 to 2000



114

BREAST CANCER MORTALITY RATES

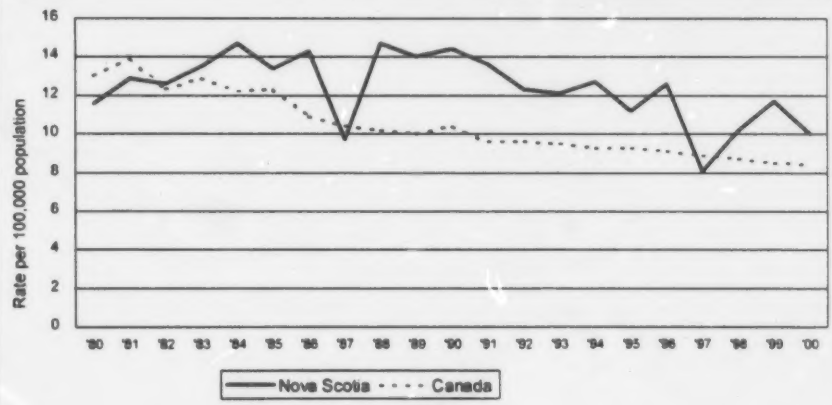
Rates Per 100,000 Age -Standardized to the 1991 Canadian Population
(Female) - Nova Scotia and Canada 1980 to 2000



115

CERVICAL CANCER INCIDENCE RATES

Rates Per 100,000 Age-Standardized to the 1991 Canadian Population
(Female) - Nova Scotia & Canada 1980 to 2000



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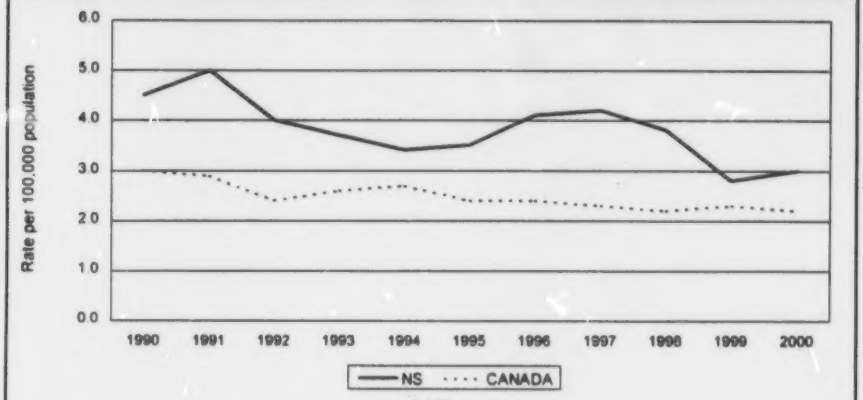
CERVICAL CANCER MORTALITY RATES

Rates Per 100,000 Age-Standardized to the 1991 Canadian Population (Female) - Nova Scotia and Canada 1990 to 2000



DATA DICTIONARY

DATA DICTIONARY
ANNUAL STATISTICAL REPORT 2000/01

A NOTE ON THIS DICTIONARY

This dictionary was designed for use with slides from the Annual Statistical Report (2000/2001). The Performance Measurement and Health Informatics Section of the Information Management Branch, Nova Scotia Department of Health compiled the report with consultation from the various programs whose data are presented herein. The Report consists of a slide show, a data dictionary, and a brief interpretive text. The interpretive text offers an overview of the graphical information within the Annual Report while the dictionary provides technical background. The dictionary entries are numbered in the same format as the Power Point™ slide show. The slides are grouped by topic or program area within the Department of Health (*e.g.* Tobacco Control or Addictions Services).

A NOTE ON POPULATIONS

Following are the Nova Scotia District Health Authorities populations from the 1991 and 1996 census, as provided by Statistics Canada and the Nova Scotia Department of Finance and intercensal estimates for 1992 to 1995 and 1997 to 1999 with a projection for 2000. District Health Authorities' populations have been compiled using these numbers.

	NOVA SCOTIA	DHA1	DHA2	DHA3	DHA4	DHA5	DHA6	DHA7	DHA8	DHA9
1991 CENSUS	915,077	61,470	67,513	81,342	68,721	34,820	50,417	50,755	144,706	355,333
1992 ESTIMATE	919,363	61,500	67,475	82,036	69,592	34,698	50,357	50,725	144,699	358,281
1993 ESTIMATE	923,717	61,460	67,401	82,375	70,425	34,761	50,233	50,783	144,665	361,614
1994 ESTIMATE	926,332	61,440	67,002	82,769	70,942	34,801	50,015	50,650	144,360	364,353
1995 ESTIMATE	927,723	61,464	66,484	83,065	71,142	34,552	49,777	50,291	143,537	367,411
1995 ESTIMATE	927,723	61,464	66,484	83,065	71,142	34,552	49,777	50,291	143,537	367,411
1996 CENSUS	931,254	61,285	66,262	83,479	71,612	34,562	49,819	50,132	142,681	371,422
1997 ESTIMATE	934,549	61,229	65,991	84,021	72,022	34,477	49,771	49,757	141,428	375,853
1998 ESTIMATE	936,126	61,159	65,647	84,262	72,557	34,282	49,418	49,464	139,473	379,864
1999 ESTIMATE	939,236	61,176	65,420	84,844	72,755	34,017	49,497	49,281	138,338	383,908
2000 PROJECTION	941,008	61,109	65,090	85,199	73,054	33,765	49,325	49,015	136,717	387,734

A NOTE ON READING DATA

There are many ways to present numerical information. Generally speaking, the more numerals to the right of the decimal point the more precise the number. Conversely, the fewer the numerals to the right of the decimal point the less precise the number and the more rounding error introduced. Difficulty arises when attempting to illustrate numerical information graphically. There must be a balance between precision and legibility.

In the slide show from this annual report, as an aid to readability most graphs do not show numerals to the right of the decimal place. By aiming for a clearer presentation of data the overall usefulness of the graph increases. However, since data are shown in a rounded form, a small amount of rounding error is introduced. This error is negligible and does not affect the precision of this slide show in any meaningful way. Performance Measurement and Health Informatics, NSDoH, has the original data tables for each slide including numerals to the right of the decimal place (where possible).

Not all data presented in the slide show are decimal free. Where the variation between data points is small or where the Y-axis scale is less than 10 units, the data are then illustrated with one numeral to the right of the decimal place.

Issues regarding data presentation are not the only considerations necessary to read this annual report properly. Another set of considerations is the manner in which data are created. Under certain circumstances data, which appear, on first glance, to be exactly the same, are different in subsequent slides. This is most often seen in procedure rates per 100,000 and is due to due to several factors, such as differences in definitions or different data sources; or crude rate versus age-standardized rates. Neither number is incorrect; they are simply the results of different formulae. Therefore, frequent reference to the details in this data dictionary will allow the reader to make informed use of the data presented.

A NOTE ON RATES[1]

Different geographic areas or different time periods may not have similar population structures; *e.g.*, there may be different proportions of young and old people, male and female, *etc.* For this discussion mortality rates will be used throughout. Mortality rates will be different at different times and locations.

A crude, or unadjusted, rate is calculated by taking the number of deaths in a geographic area in a period of time and dividing that number by the population (usually taken at the midpoint of the time period) in that geographic area, *i.e.*:

$$\frac{\textbf{\textit{Deaths}}}{\textbf{\textit{Population}}}$$

[1] Information on crude and age/sex-standardized rates was provided by Dr. David Elliott, Performance Measurement and Health Informatics, Nova Scotia Department of Health.

To avoid decimals, it is customary to express this as a rate per 100,000 persons:

$$\frac{\textit{Deaths X 100,000}}{\textit{Population}}$$

An additional step can be taken to adjust these rates to correct for population differences through a process called standardization.

Process to standardize rates:

- A crude rate for each specific age (and sex) cohort (for example women aged 15 to 19) is divided by the population estimate for the same age (and sex) cohort.
- These crude rates are multiplied by a weight (calculated by dividing the 1991 Canadian population in the specific cohort by the total population)
- The weighted rates are then added together across all age (and sex) cohorts to produce an age (and sex) standardized mortality rate.

The process of standardizing removes the effects of age (and/or sex) in a population. The resulting age (and sex) standardized rate provides a fairer comparison between geographic areas and different time periods than does the crude rate.

Canadian rates for acute care procedures and indicators are taken from the CIHI publication "Health Care in Canada 2001".

SLIDES

1. **ANNUAL REPORT – 2000/01**

2. **ANNUAL REPORT – DATA NOTES – A Guide to Using the Data**

3. **ACUTE CARE**

4. **PATIENT DAYS PER 1000 POPULATION – Nova Scotia –1992/93 to 2000/01 –Excludes Newborns**

Background: Patient Days per 1000 Population - Inpatient separations from hospital and corresponding patient days of care expressed as a rate per 1000 population for a specified time period.

Formula: (The total days stay of those patients separated from hospital / the yearly N. S. population estimate) X 1000.

Incl: Includes acute medical, surgical and psychiatric hospital days.

Excl: Excludes Veterans Affairs of Canada (VAC), newborns, and out-of-province patients.

Source: Nova Scotia Department of Health/Admission-Separation Discharge System (NSDoH ASD hereafter) 1990/91 to 1994/95; Nova Scotia Department of Health/Canadian Institute of Health Information

Discharge Abstracting Database (NSDoH CIHI DAD hereafter) 1995/96 to 2000/01. Population figures are from Statistics Canada population estimates as of June 2001.

5. PATIENT DAYS PER 1000 POPULATION - Crude Rates per 1000 Population by DHA of Residence - 2000/01 - Excludes Newborns

Background: Patient Days per 1000 Population - Inpatient separations from hospital and corresponding patient days of care by District of patient's residence, expressed as a rate per 1000 population for a specified time period.

Formula: (The total days stay of those patients separated from hospital by DHA of residence / the yearly N.S. population estimate by DHA) X 1000.

Incl: Includes acute medical, surgical, psychiatric hospital days, and rehabilitation (non-acute).

Excl: Excludes Veterans Affairs of Canada (VAC), newborns, and out-of-province patients.

Source: CIHI DAD, NSDoH, Statistics Canada.

6. PATIENT DAYS PER 1000 POPULATION - Days per 1000 Population Age-Standardized to the 1991 Canadian Population - by DHA of Residence - 2000/01 - Excludes Newborns

Background: Patient Days per 1000 Population - Inpatient separations from hospital and corresponding patient days of care by DHA residence, expressed as a rate per 1000 population for a specified time period.

Formula: ((The total days stay of those patients separated from hospital by age group / the yearly N.S. population estimate by DHA of residence) X Standardizing Process) X 1000.

Incl: Includes acute medical, surgical, psychiatric hospital days.

Excl: Excludes Veterans Affairs of Canada (VAC), newborns, and out-of-province patients.

Source: CIHI DAD, NSDoH, Statistics Canada.

7. BEDS PER 1000 POPULATION - Nova Scotia 1992/93 to 2000/01

Background: The number of acute care beds per unit population on a provincial level.

Formula: (The total number of acute care beds / the yearly N. S. population estimate) X 1000.

Incl: Includes acute care, mental health, and rehabilitation services.

Excl: Excludes Veterans Affairs of Canada (VAC) beds, Detoxification Beds, and Level 2 beds.

Source: Performance Measurement & Health Informatics, NSDoH.

8. AVERAGE LENGTH OF STAY- Acute Care - Nova Scotia – 1992/93 to 2000/01 - Excluding Newborns

Background: Average Length of Stay (ALOS) - Average of the length of stay for a select group of patients.

Formula: The total length of stay of patients separated from hospital / the total separations for patients for a specified time period.

Incl: This includes all days and separations for medical, surgical, and psychiatric cases.

Excl: Excludes VAC and newborns.

Source: NSDoH ASD System 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to 2000/01, NSDoH.

9. AVERAGE LENGTH OF STAY 2000/01 - Acute Care - by DHA of Residence - 2000/01 - Excluding Newborns

Background: Average Length of Stay (ALOS) - Average of the length of stay for a select group of patients, by DHA of residence.

Formula: The total length of stay of patients separated from hospital from a particular District of residence / the total separations for patients from a particular District of residence for a specified time period.

Incl: This includes all days and separations for medical, surgical, and acute psychiatric cases.

Excl: Excludes VAC, newborns, forensic and long-term mental health care, and out-of-province patients.

Source: NSDoH CIHI DAD, NSDoH.

10. AVERAGE LENGTH OF STAY 2000/01 - Acute Care by DHA of Hospitalization - 2000/01 - Excluding Newborns

Background: Average Length of Stay (ALOS) - Average of the length of stay for a select group of patients, by District of patient's hospitalization.

Formula: The total length of stay of patients separated from hospital from a particular District / the total separations for patients from a particular District of hospitalization for a specified time period.

Incl: This includes all days and separations for medical, surgical, and acute psychiatric cases.

Excl: Excludes VAC, newborns, and forensic and long-term mental health care.

Source: NSDoH CIHI DAD, NSDoH.

11. ALTERNATE LEVEL OF CARE (ALC) DAYS PER 1000 POPULATION - Crude Rates per 1000 Population by DHA of Residence 2000/01

Background: Alternate Level of Care (ALC hereafter) Days per 1000 population – corresponding patient days of care for inpatient separations provided to a patient who has finished the acute care phase of his/her treatment. ALC status is indicated by the physician or designated other. These patients still occupy an acute care bed while awaiting transfer to another form of care, for example, chronic care, long-term care, or rehabilitation.

Formula: (The total of the ALC length of stay of those patients separated from hospital / the 2000/01 Nova Scotia District population estimates) X 1000.

Source: NSDoH CIHI DAD, NSDoH

12. MAY NOT REQUIRE HOSPITALIZATION (MNRH) - Separations and Days - By DHA of Hospital 2000/01

Background: May not require hospitalization (MNRH hereafter) separations and days refer to those diagnoses and procedures for which the patients do not necessarily require hospitalization. For example sinusitis, tonsillectomy, and adenoidectomy are counted as MNRH's. The various MNRH diagnoses and procedures do not exclude the possibility of hospitalization, however, they do not demand it either. In other words this measure encompasses a 'gray-area' of hospital admissions and a potential area for utilization review.

Formula: The number of hospital separations and the number of days in hospital per separation for all diagnoses and procedures flagged by CIHI as MNRH.

Source: NSDoH CIHI DAD, NSDoH

13. ELECTIVE SURGERY - PERCENTAGE PERFORMED ON THE DAY OF ADMISSION - Nova Scotia - 1992/93 to 2000/01

Background: Same Day Admission surgery is a program where elective surgery is performed on the day of hospital admission (admission date=procedure date) with all preparatory investigation completed prior to admission. Such pre-admission testing practices can decrease unnecessary and expensive days spent in hospital. Surgical cases are found using the procedure location of main operating room or endoscopic room. (Excludes Obstetrical Procedures ICD-9-CM code ranges 72.0 - 75.99).

Formula: (The number of elective separations with surgery performed on the day of hospital admission / the total number of elective separations having surgery) **X** 100.

Incl: Out-of-province patients and newborns are included.

Source: NSDoH ASD 1992/93 to 1994/95; NSDOH CIHI DAD 1995/96 to 2000/01, NSDoH.

14. ELECTIVE SURGERY - PERCENTAGE PERFORMED ON THE DAY OF HOSPITAL ADMISSION - By DHA of Hospitalization - 2000/01

Background: Same Day Admission surgery is a program where elective surgery is performed on the day of admission (admission date = procedure date) with preparatory investigation completed outside of hospital prior to admission. Such pre-admission testing practices can decrease unnecessary and expensive days spent in hospital. Surgical cases are found using the procedure location of main operating room or endoscopic room. (Excludes Obstetrical Procedures ICD-9-CM code ranges 72.0 - 75.99).

Formula: (The number of elective separations with surgery performed on the day of hospital admission / the total number of elective separations having surgery) **X** 100.

Incl: Out-of-province patients and newborns are included.

Source: NSDoH CIHI DAD 2000/01.

15. ELECTIVE DAY SURGERY AS A PERCENTAGE OF ALL ELECTIVE SURGERY - Nova Scotia - 1995/96 to 2000/01

Background: Principal day surgery procedure cases as a percentage of all principal surgical procedure cases. Day surgery is a service provided to a patient who is pre-booked. The service requires a sterile environment and recovery procedures and, does not require admission to an inpatient bed. Day surgery and inpatient surgical cases are based on elective separations only. To identify surgical cases CIHI's "principal operative procedure" code was applied and locates the main operating room or endoscopic room. Day surgeries have traditionally been pre-booked. Several facilities prefer to only report on elective operating room procedures to provide a more accurate picture of potential utilization and / or improvements.

Formula: (The total number of elective Day surgery cases / the number of elective Day surgery cases + number of elective inpatient surgery cases) **X** 100.

Incl: Newborns are included.

Excl: Procedures performed in Ambulatory Care settings or Outpatient clinics are not included.

Source: NSDoH CIHI DAD 1995/96 to 2000/01

16. ELECTIVE DAY SURGERY AS A PERCENTAGE OF ALL ELECTIVE SURGERY - By DHA of Hospitalization - 2000/01

Background: Principal day surgery procedure cases as a percentage of all principal surgical procedure cases. Day surgery is a service provided to a patient who is pre-booked. The service requires a sterile environment and recovery procedures and, does not require admission to an inpatient bed. Day surgery and inpatient surgical cases are based on elective separations only. To identify surgical cases CIHI's "principal operative procedure" code was applied and locates the main operating room or endoscopic room. Day surgeries have traditionally been pre-booked. Several facilities prefer to only report on elective operating room procedures to provide a more accurate picture of potential utilization and / or improvements.

Formula: (The total number of elective Day surgery cases / the number of elective Day surgery cases + number of elective inpatient surgery cases) X 100.

Incl: Newborns are included.

Excl: Procedures performed in Ambulatory Care settings or Outpatient clinics are not included.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

17. INGUINAL/FEMORAL HERNIA REPAIRS PERCENTAGE DONE AS DAY SURGERY- Nova Scotia - 1995/96 to 2000/01

Background: Repair of a hernia (bilateral or unilateral) in the groin area of the body. ICD-9-CM procedure codes 53.0-3 were used.

Formula: (The number of principal procedures (i.e. inguinal hernia repairs) performed on a Day surgery basis / (the number of principal procedures (i.e. inguinal hernia repairs) (performed on a Day surgery basis + the number performed on an inpatient basis)) X 100.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

18. LAPAROSCOPIC CHOLECYSTECTOMIES - Percentage Performed as Day Surgery - Nova Scotia 1995/96 to 2000/01

Background: Removal of the gallbladder, laparoscopically (by scope). Cholecystectomy ICD-9-CM procedure code 51.23 was used.

Formula: (The number of principal procedures (i.e. laparoscopic cholecystectomies) performed on a Day surgery basis / (the number of principal procedures performed on a Day surgery basis + the number performed on an inpatient basis)) X 100.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

19. LAPAROSCOPIC CHOLECYSTECTOMIES - As a Percentage of All Cholecystectomies - Nova Scotia - 1995/96 to 2000/01

Background: Removal of the gallbladder, all approaches, open and closed (by scope). ICD-9-CM procedure codes 51.22 (total or open cholecystectomy) and 51.23 (laparoscopic) were used.

Formula: (The number of laparoscopic cholecystectomies performed / (the number of total cholecystectomies + performed on an inpatient basis)) **X** 100.

Source: NSDoH CIHI DAD 1995/96 to 2000/01

20. TOTAL HIP REPLACEMENTS - Crude Rates per 100,000 Population - Nova Scotia - 1995/96 to 2000/01

Background: Surgical removal of the hip joint with replacement by a synthetic hip joint. ICD-9-CM code 81.51 was used.

Formula: (The number of principal procedures performed (i.e. Total Hip Replacements) per District of residence / the population estimate per District) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01

21. TOTAL HIP REPLACEMENTS - Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia 1995/96 to 2000/01

Background: Surgical removal of the hip joint with replacement by a synthetic hip joint. ICD-9-CM code 81.51 was used.

Formula: ((The number of principal procedures performed (i.e. Total Hip Replacements) per District of residence / the population estimate per District) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01

22. TOTAL HIP REPLACEMENTS - 2000/01 Rates per 100,000 Age-Standardized to the 1991 Canadian Population - by DHA of Residence

Background: Surgical removal of the hip joint with replacement by a synthetic hip joint. ICD-9-CM procedure code 81.51 was used.

Formula: (The number of principal procedures performed (i.e. Total Hip Replacements) per District / the population estimate per District) **X** Standardizing Process) **X** 100,000

Source: NSDoH CIHI DAD 1995/96 to 2000/01

23. TOTAL KNEE REPLACEMENTS - Crude Rates per 100,000 Population - Nova Scotia - 1995/96 to 2000/01

Background: Surgical removal of the knee joint with replacement by a synthetic knee joint. ICD-9-CM procedure code 81.54 was used.

Formula: (The number of principal procedures performed (i.e. Total Knee Replacements) per District / the population estimate per District) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01

24. TOTAL KNEE REPLACEMENTS - Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia 1995/96 to 2000/01

Background: Surgical removal of the knee joint with replacement by a synthetic knee joint. ICD-9-CM procedure code 81.54 was used.

Formula: ((The number of principal procedures performed (i.e. Total Knee Replacements) per District / the population estimate per District) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01

25. TOTAL KNEE REPLACEMENTS - 2000/01 Rates per 100,000 Age-Standardized to the 1991 Canadian Population - by DHA of Residence

Background: Surgical removal of the knee joint with replacement by a synthetic knee joint. ICD-9-CM procedure code 81.54 was used.

Formula: ((The number of principal procedures performed (i.e. Total Knee Replacements) per District / the population estimate per District) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01

26. HYSTERECTOMIES - Crude Rates per 100,000 (Female) Population - 1995/96 2000/01

Background: Removal of the uterus.

Formula: (The number of principal procedures performed (i.e. Hysterectomies) per District / the population estimate per District) **X** 100,000.

Incl: Nova Scotia used ICD-9-CM procedure codes include 68.3 subtotal abdominal hysterectomy, 68.4 total abdominal hysterectomy, 68.5 vaginal hysterectomy, 68.6 radical abdominal hysterectomy, 68.7 radical vaginal, 68.8 pelvic evisceration and 68.9 other and unspecified hysterectomy.

Source: NSDoH CIHI DAD 1995/96 to 2000/01

27. HYSTERECTOMIES - Rates per 100,000 Age Standardized to the 1991 (Female) Canadian Population - Nova Scotia 1995/96 to 2000/01

Background: Removal of the uterus.
Formula: **((**The number of principal procedures performed (i.e. Hysterectomies) per District **/** the population estimate per District**) X** Standardizing Process**) X** 100,000.
Incl: Nova Scotia used ICD-9-CM procedure codes include 68.3 subtotal abdominal hysterectomy, 68.4 total abdominal hysterectomy, 68.5 vaginal hysterectomy, 68.6 radical abdominal hysterectomy, 68.7 radical vaginal, 68.8 pelvic evisceration and 68.9 other and unspecified hysterectomy.
Source: NSDoH CIHI DAD 1995/96 to 2000/01

28. HYSTERECTOMIES 2000/01 Rates per 100,000 - Age-Standardized to the 1991 Canadian Population - by DHA of Residence

Background: Removal of the uterus.
Formula: **(**The number of principal procedures performed (i.e. Hysterectomies) per District **/** the population estimate per District**) X** Standardizing Process**) X** 100,000.
Incl: Nova Scotia used ICD-9-CM procedure codes include 68.3 subtotal abdominal hysterectomy, 68.4 total abdominal hysterectomy, 68.5 vaginal hysterectomy, 68.6 radical abdominal hysterectomy, 68.7 radical vaginal, 68.8 pelvic evisceration and 68.9 other and unspecified hysterectomy.
Source: NSDoH CIHI DAD 1995/96 to 2000/01.

29. CARDIAC CATHETERIZATIONS - Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia – 1995/96 to 2000/01

Background: The insertion of a cardiac catheter into the right or left heart chambers for the detection of cardiac abnormalities. Day patient cardiac catheterizations had not been coded at the QEII until 1999/00 unless a myocardial biopsy or angioplasty was performed during the same operative episode. (Effective 1999/2000, all day surgery procedures performed in the Cardiac Catheterization Lab captured for CIHI.) Procedure codes 37.21 to 37.23 were used.

Formula: ((The number of principal procedures performed (i.e. Cardiac Catheterizations) per District / the population estimate per District) X Standardizing Process) X 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

30. CARDIAC CATHETERIZATIONS 2000/01 Rates per 100,000 Age-Standardized to the 1991 Canadian Population – by DHA of Residence

Background: The insertion of a cardiac catheter into the right or left heart chambers (atria and ventricles) for the detection of cardiac abnormalities. Day patient cardiac catheterizations have not been coded at the QEII unless a myocardial biopsy or angioplasty was performed during the same operative episode. (Effective 1999/2000, all day surgery procedures performed in the Cardiac Catheterization Lab will be captured for CIHI.) Procedure codes 37.21 to 37.23 were used.

Formula: ((The number of principal procedures performed (i.e. Cardiac Catheterizations) per District / the population estimate per District) X Standardizing Process) X 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

31. CORONARY ANGIOPLASTIES - Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia - 1995/96 to 2000/01

Background: Dilation of an obstructed coronary artery or the procedural removal of a thickened coronary arterial intima (using a balloon-tipped catheter), inserted through the femoral or other artery, with or without infusion of a thrombus-destroying substance. Procedure codes 36.01 (single percutaneous transluminal coronary angioplasty - PTCA w/o thrombolytic), 36.02 (single PTCA with thrombolytic) and 36.05 (multiple vessel PTCA with/without thrombolytic were used).

Formula: ((The number of principal procedures performed (i.e. Coronary Angioplasties) per District / the population estimate per District) X Standardizing Process) X 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

32. CORONARY ANGIOPLASTIES - 2000/01 Rates per 100,000 Age-Standardized to the 1991 Canadian Population – by DHA of Residence

Background: Dilation of an obstructed coronary artery or the procedural removal of a thickened coronary arterial intima (using a balloon-tipped catheter),

inserted through the femoral or other artery, with or without infusion of a thrombus-destroying substance. Procedure codes 36.01 (single percutaneous transluminal coronary angioplasty - PTCA w/o thrombolytic), 36.02 (single PTCA with thrombolytic) and 36.05 (multiple vessel PTCA with/without thrombolytic were used).

Formula: (The number of principal procedures performed (i.e. Coronary Angioplasties) per District / the population estimate per District) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

33. CORONARY ARTERY BYPASS GRAFT - Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia – 1995/96 to 2000/01

Background: Restoration of coronary blood flow by a tubular surgical bypass (grafted mammary artery or saphenous vein) of an occluded coronary artery. ICD-9-CM procedure codes 36.10-36.19 were used.

Formula: (The number of principal procedures performed (i.e. coronary artery bypass graft (CABG's)) per District / the population estimate per District) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

34. CORONARY ARTERY BYPASS GRAFT 2000/01 Rates per 100,000 Age-Standardized to the 1991 Canadian Population – by DHA of Residence

Background: Restoration of coronary blood flow by a tubular surgical bypass (grafted mammary artery or saphenous vein) of an occluded coronary artery. ICD-9-CM procedure codes 36.10-36.19 were used.

Formula: (The number of principal procedures performed (i.e. coronary artery bypass graft (CABG's)) per District / the population estimate per District) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

35. CARDIOVASCULAR SURGERY WAIT TIMES (URGENT) by Category and Month – April 2000 to March 2001

Background: Maximum wait time in days for cardiovascular surgery for urgent patients by month. **Urgent** patients are critically ill and cannot be discharged from hospital prior to receiving surgery. They have failed maximal medical therapy and remain unstable. The current wait time standard is 7 days. **Semi-Urgent "A"** patients are unstable, have failed medical therapy and are at significant risk of heart attack or heart failure

and mortality. In many instances, patients are transferred back to their District hospital while arrangements are being made to have surgery. The current wait time standard is 2-3 weeks. **Semi-Urgent "B"** patients have coronary artery disease and are doing poorly on medical therapy. They would have chest pain walking 1-2 blocks and are incapable of employment. If these patients can exercise greater than 2 mets (a met is a standardized score on a cardiac stress test) but less than 5 mets during a stress ECG test they fall into this category. The current wait time standard is 6-8 weeks.

Formula: The total number of days waiting between the procedure booking date (by the referring physician) and the date of the procedure.

Source: Divisions of Cardiology and Cardiovascular Surgery, QEII Health Sciences Centre Monthly Wait Times.

36. CARDIOVASCULAR SURGERY WAIT TIMES (ELECTIVE) – by Month – April 2000 to March 2001

Background: Maximum wait time in days for cardiovascular surgery for elective patients by month. **Elective** patients are stable on medical therapy; unable to work due to cardiac limitations; and felt to further improve with bypass surgery. The current waiting time standard is 3 months.

Formula: The total number of days waiting between the procedure booking date (by the referring physician) and the date of the procedure.

Source: Divisions of Cardiology and Cardiovascular Surgery, QEII Monthly Wait Times.

37. NON-ELECTIVE READMISSIONS TO THE SAME HOSPITAL WITHIN ONE WEEK OF DISCHARGE - By DHA of Hospitalization - 2000/01

Background: These non-elective readmission patients have been readmitted for a diagnosis, which is the same or related to conditions treated in the previous admission to hospital. These readmissions are classified according to the CIHI Abstracting Manual guidelines.

Formula: (The number of readmissions (admission category = emergent or urgent) with same or related diagnosis within seven (7) days of previous treatment / the total number of patient separations (admission category = emergent or urgent)) X 100.

Incl: Urgent and emergent readmissions.

Excl: This measure excludes patient services 50, 51, 52, 53, 54 and 59.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

38. NON-ELECTIVE READMISSIONS TO SAME HOSPITAL WITHIN ONE MONTH OF DISCHARGE - By DHA of Hospitalization - 2000/01

Background: These non-elective readmission patients have been readmitted for a diagnosis, which is the same or related to conditions treated in the previous admission to hospital. These readmissions are classified according to the CIHI Abstracting Manual guidelines (readmission categories 1 and 3).

Formula: (The number of readmissions (admission category = emergent or urgent) with same or related diagnosis within thirty (30) days of previous treatment / the total number of patient separations (admission category = emergent or urgent)) **X** 100.

Incl: Urgent and emergent readmissions.

Excl: This measure excludes patient services 50, 51, 52, 53, 54 and 59.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

39. AVERAGE NUMBER OF DAYS OVER/UNDER CIHI EXPECTED LENGTH OF STAY (ELOS) - Nova Scotia – by DHA of Residence

Background: The average number of actual days in acute care hospitals compared to the expected length of stay. Expected length of stay (ELOS) is derived from the Case Mix Group (CMG) methodology using calibration for a given year. ELOS is calculated on typical patients taking into account the reason for hospitalization, age, comorbidity, and complications. Established by CIHI. A positive value indicates the actual days stay was longer than expected while a negative value suggests the average actual stay was shorter than expected.

Formula: (Sum (Actual Length of Stay) – Sum (Expected length of stay)) / Number of separations

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

40. PNEUMONIA/INFLUENZA – Rates per 100,000 Age-Standardized to the 1991 Canadian Population – (≥ 65 Years) Nova Scotia 1998 to 2000/01

Background: This indicator, which shows hospitalizations due to pneumonia or influenza, attempts to reflect the burden of illness due to pneumonia and influenza, a portion of which may be preventable through influenza and pneumococcal immunization programs. High rates of hospital admission for preventable pneumonia and influenza may suggest a problem with access to immunization. The indicator is per 100,000 population age 65 or older.[1] High hospitalization rates for these conditions may reflect limited utilization or access to primary care services.

[1] CIHI: Health Indicators 2001: Definitions, Data Sources and Rationale

Formula: (The number of hospital admissions for a most responsible diagnosis of ICD-9-CM codes 480 to 487 per District / the population estimate per District) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01 exclude Nova Scotia Hospital.

41. PNEUMONIA/INFLUENZA – Rates per 100,000 Age-Standardized to the 1991 Canadian Population (≥ 65 Years) – by DHA of Residence – 2000/01

Background: This indicator, which shows hospitalizations due to pneumonia or influenza, attempts to reflect the burden of illness due to pneumonia and influenza, a portion of which may be preventable through influenza and pneumococcal immunization programs. High rates of hospital admission for preventable pneumonia and influenza may suggest a problem with access to immunization. The indicator is per 100,000 population age 65 or older.[2]

Formula: ((The number of separations with a most responsible diagnosis of ICD-9-CM codes 480 to 487 per District / the population estimate per District) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01 exclude Nova Scotia Hospital.

42. AMBULATORY CARE SENSITIVE CONDITIONS – Separations per 100,000 Age-Standardized to the 1991 Canadian Population – Nova Scotia 1998/99 to 2000/01

Background: While not all admissions for ambulatory care sensitive conditions are avoidable, it is assumed that appropriate prior ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The "right" level of utilization is not known although a disproportionately high rate is presumed to reflect problems in obtaining access to primary care.[3] These conditions are based on a list developed by Alberta Health and are most responsible ICD-9-CM codes of 250 (diabetes), 291-292 (alcoholic and drug psychoses), 300 (neurotic disorders), 303-305 (alcohol and drug dependence), 311 (depression), 401-405 (hypertension) and 493 (asthma).

Formula: ((The number of separations with a selected most responsible per District / the population estimate per District) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01 exclude Nova Scotia Hospital.

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[2] CIHI: Health Indicators 2001: Definitions, Data Sources and Rationale
[3] CIHI: Health Indicators 2001: Definitions, Data Sources and Rationale

43. AMBULATORY CARE SENSITIVE CONDITIONS – Separations per 100,000 Age-Standardized to the 1991 Canadian Population – by DHA of Residence - Nova Scotia 2000/01

Background: While not all admissions for ambulatory care sensitive conditions are avoidable, it is assumed that appropriate prior ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The "right" level of utilization is not known although a disproportionately high rate is presumed to reflect problems in obtaining access to primary care.[4] These conditions are based on a list developed by Alberta Health and are most responsible ICD-9-CM codes of 250 (diabetes), 291-292 (alcoholic and drug psychoses), 300 (neurotic disorders), 303-305 (alcohol and drug dependence), 311 (depression), 401-405 (hypertension) and 493 (asthma).

Formula: ((The number of separations with a selected most responsible per District / the population estimate per District) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD 1995/96 to 2000/01 exclude Nova Scotia Hospital.

44. INFLOW/OUTFLOW RATIO – by District Health Authority 2000/01

Background: This indicator was developed by CIHI. It reflects the balance between the volumes of hospital stays provided to both residents and non-residents by all acute care hospitals in a given District Health Authority and the extent of acute hospital utilization by residents of that same District Health Authority, whether they receive care within or out of the DHA. A ratio of less than one indicates that hospital stays utilized by residents of a DHA exceeded hospital care provided within that DHA, suggesting an outflow effect. A ratio greater than one indicates hospital stays provided by a DHA exceeded the quantity of stays utilized by its residents, suggesting an inflow effect. A ratio of one indicates that the volume of hospital discharges in the DHA is equivalent to that generated by its residents, suggesting that inflow and outflow activity, if it exists at all, is balanced.

Formula: The numbers of separations (discharges and deaths) from acute care hospitals within a given region over the denominator: the number of hospital separations generated by residents of a given district, where region is specified in the numerator.

Source: NSDoH CIHI DAD 1995/96 to 2000/01

[4] CIHI: Health Indicators 2001: Definitions, Data Sources and Rationale

45. MENTAL HEALTH PROGRAMS

46. MENTAL HEALTH PROGRAMS - Inpatient Separations - Adults (≥ 19 Years) Nova Scotia - Excluding Forensic and Extended Care Units - 2000/01

Background: Mental Health services in Nova Scotia have developed a clustering of ICD-9-CM diagnosis codes to group similar diagnoses.

Formula: The sum of in-patient separations from each patient service (64 - psychiatry and 65 - pediatric psychiatry) for each diagnostic group for all hospitals with a designated psychiatric unit.

Excl: Separations from Forensic and Extended Care Units, out of province patients and acute care patients with a length of stay of more than 731 days.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

47. MENTAL HEALTH PROGRAMS - Patient Days - Adults (≥ 19 Years) Nova Scotia - Excludes Forensic and Extended Care Units - 2000/01

Background: Mental Health services in Nova Scotia have developed a clustering of ICD-9-CM diagnosis codes to group similar diagnoses.

Formula: The sum of in-patient days from each patient service (64 - psychiatry and 65 - pediatric psychiatry) for each diagnostic group for all hospitals with a designated psychiatric unit.

Excl: Separations from Forensic and Extended Care Units, out of province patients and acute care patients with a length of stay of more than 731 days.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

48. MENTAL HEALTH PROGRAMS - Inpatient Separations - Children (≤18 Years) Nova Scotia - Excludes Forensic and Extended Care Units - 2000/01

Background: Mental Health services in Nova Scotia have developed a clustering of ICD-9-CM diagnosis codes for grouping similar diagnoses.

Formula: The sum of in-patient separations from each patient service (64 - psychiatry and 65 - pediatric psychiatry) for each diagnostic group for all hospitals with a designated psychiatric unit.

Excl: Separations from Forensic and Extended Care Units, out of province patients and acute care patients with a length of stay of more than 731 days.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

49. **MENTAL HEALTH PROGRAMS - Patient Days - Children (≤18 Years) Nova Scotia - Excludes Forensic and Extended Care Units - 2000/01**

Background: Mental Health services in Nova Scotia have developed a clustering of ICD-9-CM diagnosis codes for grouping similar diagnoses.

Formula: The sum of all in-patient days from each patient service (64 - psychiatry and 65 - pediatric psychiatry) for each diagnostic group for all hospitals with a designated psychiatric unit.

Excl: Separations from Forensic and Extended Care Units, out of province patients and acute care patients with a length of stay of more than 731 days.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

50. **MENTAL HEALTH PROGRAMS PATIENT DAYS PER 1000 POPULATION - Acute Psychiatric Care by DHA of Residence - Crude Rates per 1000 Population - 2000/01**

Background: Patient Days per 1000 Population - Acute inpatient mental health patient days of care by DHA of patient's residence.

Formula: (The total days stay of those patients separated from hospital with a designated psychiatric unit (acute mental health care) by age group / the yearly Nova Scotia population estimates by District) **X** 1000. Use patient service codes 64.1 to 64.5, 64.7, 65.1, and 65.2.

Incl: Rate includes only acute psychiatric hospital days.

Excl: This indicator excludes separations from Forensic and Extended Care units and out-of-province residents.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

51. **MENTAL HEALTH PROGRAMS - INPATIENT SEPARATIONS - Acute Psychiatric Care - Adults (≥ 19 Years) - Nova Scotia – 1996/97 to 2000/01**

Background: Separations from designated psychiatric units in Nova Scotia hospitals. This definition includes acute psychiatric units in general and psychiatric hospitals. While adults usually occupy these units, teenagers may also be admitted to acute psychiatric units. Adults are defined as 19 and over years of age (child mental health services end at 18 years of age).

Formula: The sum of all in-patient separations age 19 years and older from each patient service (64 - psychiatry and /or 65 - pediatric psychiatry) by fiscal year.

Excl: Separations from Forensic and Extended Care Units and out of province patients.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

52. MENTAL HEALTH PROGRAMS - INPATIENT DAYS - Acute Psychiatric Care - Adults (≥ 19 Years) - Nova Scotia – 1996/97 to 2000/01

Background: Separations from designated psychiatric units in Nova Scotia hospitals. This definition includes acute psychiatric units in general and psychiatric hospitals. While adults usually occupy these units, teenagers may also be admitted to acute psychiatric units. Adults are defined as 19 and over years of age (child mental health services end at 18 years of age).

Formula: The sum of all in-patient discharge days for adults 19 years of age and older from each patient service (64 - psychiatry and 65 - pediatric psychiatry) by fiscal year.

Excl: Separations from Forensic and Extended Care Units and out of province patients.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

53. MENTAL HEALTH PROGRAMS - INPATIENT SEPARATIONS - Acute Psychiatric Care - Children (≤ 18 Years) - Nova Scotia – 1996/97 to 2000/01

Background: Separations from designated psychiatric units in Nova Scotia hospitals. This definition includes acute psychiatric units in general and psychiatric hospitals. While children usually occupy these units, teenagers may also be admitted to acute psychiatric units. Children are defined as 18 years of age and younger.

Formula: The sum of all in-patient separations for children 18 years of age and younger from each patient service (64 - psychiatry and /or 65 - pediatric psychiatry) by fiscal year.

Excl: Separations from Forensic and Extended Care Units and out of province patients.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

54. MENTAL HEALTH PROGRAMS - INPATIENT DAYS - Acute Psychiatric Care - Children (≤18 Years) - Nova Scotia - 1996/97 to 2000/01

Background: Separations from designated psychiatric units in Nova Scotia hospitals. This definition includes acute psychiatric units in general and psychiatric hospitals. While children usually occupy these units, teenagers may also be admitted to acute psychiatric units. Children are usually defined as 18 years of age and younger.

Formula: The sum of all in-patient discharge days for children 18 years of age and younger from each patient service (64 - psychiatry and /or 65 - pediatric psychiatry) by fiscal year

Excl: Separations from Forensic and Extended Care Units and out of province patients.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

55. MENTAL HEALTH PROGRAMS AVERAGE LENGTH OF STAY – Acute Psychiatric Care - Adults (≥ 19 Years) - Nova Scotia – 1996/97 to 2000/01

Background: Average Length of Stay for separations from designated psychiatric units in Nova Scotia hospitals. This definition includes acute psychiatric units in general and psychiatric hospitals. While adults usually occupy these units, teenagers may also be admitted to acute psychiatric units. Adults are defined as 19 and over years of age (child mental health services end at 18 years of age).

Formula: The sum of all in-patient discharge days for adults 19 years of age and older from each patient service (64 - psychiatry and 65 - pediatric psychiatry) / number of separations

Excl: Separations from Forensic and Extended Care Units and out of province patients.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

56. MENTAL HEALTH PROGRAMS AVERAGE LENGTH OF STAY – Acute Psychiatric Care - by DHA of Residence - 2000/01

Background: Average Length of Stay for separations from designated psychiatric units in Nova Scotia hospitals.

Formula: The total length of stay of psychiatric patients in hospital / the total separations for those same patients for a specified period of time.

Incl: This rate includes only acute psychiatric hospital days from acute psychiatric Units in both general and psychiatric hospitals.

Excl: Separations from Forensic and Extended Care Units as well as out of province patients.

Source: NSDoH CIHI DAD 1995/96 to 2000/0

57. MENTAL HEALTH PROGRAMS - AMBULATORY CARE – Average MIS Visits per Client and Active MIS Clients per 1000 Population 1993/94 to 2000/01

Background: **Visits per Client**: average MIS visits per client is an indicator of service intensity. Unlike the active client rate (discussed below) the visits per client indicator represents the number of total MIS visits (as defined by MIS guidelines) not unique clients, and is divided by the number of clients whose files were open during the reporting period.

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Active Client Rate: Active unique MIS clients per 1000 population (refers to unique Health Card numbers). 'Active unique MIS clients' is a unique count of individuals treated within a given period, in this case, one year. The 1991 Statistics Canada Census population for Nova Scotia is used for the denominator.

Formula: **Visits per Client**: the total number of MIS visits / the number of clients with open cases during the time period under study.
Active Client Rate: **(**the number of active unique MIS clients / the 1991 Statistics Canada Census population for Nova Scotia**) X** 1000.

Source: Mental Health Outpatient Information System, Annual Reports, NSDoH.

58. MENTAL HEALTH PROGRAMS AMBULATORY CARE - Number of People Served - Mental Health Outpatient Information System (MHOIS) Unique Clients - 1993/94 to 2000/01

Background: This is a unique count of the number of people served by the outpatient Mental Health Programs in Nova Scotia.

Formula: Number of active unique MIS clients served within a specified time period (as captured by the Mental Health Outpatient Information System).

Source: Mental Health Outpatient Information System (MHOIS), Annual Reports, NSDoH.

59. MENTAL HEALTH PROGRAMS TOP DIAGNOSES - Outpatient Clinics - Adults (18 Years of Age Plus) - 2000/01

Background: The most common diagnoses of adult (18+ years of age) clients treated in outpatient mental health programs in Nova Scotia during 2000/01. 'Diagnosis Deferred' occurs when mental health therapists either do not have enough exposure to a client (for example one visit) to make proper diagnoses or the problem is difficult to diagnosis and thus the diagnosis is deferred until such time as an accurate one can be made.

Formula: Listing of the five most common / frequently occurring diagnoses for adults (18 plus years of age) in outpatient clinics.

Source: MHOIS Reporting System, NSDoH.

60. MENTAL HEALTH PROGRAMS TOP DIAGNOSES – Outpatient Clinics (Ambulatory Care) - Youth (under 18) - 2000/01

Background: The most common diagnoses of youth (<18 years of age) clients treated in outpatient mental health programs in Nova Scotia during 2000/01. 'Diagnosis Deferred' occurs when mental health therapists either do not have enough exposure to a client (for example one visit) to

make proper diagnoses or the problem is difficult to diagnosis and thus the diagnosis is deferred until which time an accurate one can be made.

Formula: Listing of the five most common / frequently occurring diagnoses for youth (under 18) in outpatient clinics.

Source: MHOIS Reporting System, NSDoH.

61. ADDICTION SERVICES PROGRAMS

62. ADDICTION SERVICES PROGRAMS - Number of Clients Served – By Gender 1992/93 to 2000/01

Background: The total number of male and female clients who used Addiction Services programs in a given fiscal year. Addiction Services includes many program areas: Outpatient Services (O.P.S.), Detoxification (Withdrawal Management), Treatment Orientation Program (T.O.P.), 28 day program, CORE services (Central District only – includes education, orientation, structured treatment programs, and adolescent services). Three out four Districts have T.O.P. (Central District does not). The 28 day programs are found in Eastern and Western Districts.

Formula: The total number of unique male and the total number of unique female clients who used Addiction Services programs in a given fiscal year.

Incl: This measure includes all Addiction Services Program Areas.

Source: Nova Scotia Addiction Services Program Statistics, NSDoH.

63. ADDICTION SERVICES PROGRAMS - 2000/01 - Service Utilization Breakdown: Outpatient Services and Inpatient Services

Background: The number of clients in specified programs including: O.P.S. (Outpatient Services); Detoxification (Withdrawal Management), T.O.P. (Treatment Orientation Program), 28 Day, and CORE (Central District). Service Available in Each District Service Titles Vary Between Districts

Formula: The total number of clients in O.P.D., Detox, T.O.P., 28-Day, and CORE.

Source: Nova Scotia Addiction Services Program Statistics, NSDoH.

64. PUBLIC HEALTH

65. BREASTFEEDING RATES - NOVA SCOTIA - 1994 TO 2000 & CANADA 1994 - The Rate is Based on Women Breastfeeding at Hospital Discharge

Background: Breast feeding rates refer to the relationship between the number of women breast-feeding at the time of hospital discharge and the total

number of women giving birth whose breast-feeding status is known at hospital discharge. This relationship is expressed as a percentage. **Note**: the number of women whose breast-feeding status was known at hospital discharge is not the same number as the total number of women delivering babies (it is slightly less). Using the known breast-feeding status total as the denominator in this equation allows for increased precision in measuring breast-feeding rates.

Formula: (The number of women known to be breast-feeding at hospital discharge / the number of women whose breast-feeding status (yes or no) was known at hospital discharge) **X** 100.

Source: Nova Scotia Breast-feeding data were provided by the Reproductive Care Program. The Canadian rate was based on the publication: Survey of Routine Maternity Care and Practices in Canadian Hospitals, Canadian Institute of Child Health, Supply and Services, Canada, 1995.

66. INFLUENZA VACCINATION RATES - NOVA SCOTIA - Percentage of Adults Vaccinated (65 Years of Age Plus)

Background: The proportion of adults 65 years of age and older who receive an influenza vaccination for a specific influenza season. The *Canadian Consensus Conference on Influenza* (1993) recommends that by the 2000/01 flu season 70% of individuals in (high risk) groups should receive flu shots.

Formula: (The number of elderly patients 65 years of age and older who are immunized / Nova Scotia population aged 65 years and older) **X** 100.

Source: Public Health Programs Section, NSDoH.

67. CHLAMYDIA RATES PER 100,000 POPULATION - Nova Scotia - 1991 to 2000; Canada 1991 to 1997

Background: Chlamydia is a sexually transmitted disease (STD) caused by the Chlamydia trachomatis bacterium. Most of those infected with Chlamydia trachomatis are young people under the age of 25[5]. Furthermore Chlamydia has been suggested as a cofactor in HIV infection and is extremely dangerous (in later stages of infection) to women[6]. Therefore this STD must be monitored in the best interest of the public

Formula: (The number of chlamydia cases / Nova Scotia (for the Nova Scotian rate) and Canadian (for the Canadian rate)) **X** 100,000.

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[5] Guide to Clinical Preventive Services, 2nd. Edition, 1996, Report of the U.S. Preventive Services Task Force, Williams and Wilkins, Baltimore, Maryland, Page 326.

[6] Ibid.:325.

Source: Canadian Laboratory Centre for Disease Control, Ottawa, Report on STD Chlamydia May 1999, Health Canada and 1995 Public Health Programs, NSDOH.

68. AIDS INCIDENCE PER 100,000 POPULATION - Nova Scotia – 1991-2000

Background: An illness characterized by laboratory evidence of HIV infection and any one of 23 recognized "indicator" diseases.

Formula: The number of people who were diagnosed with AIDS / the Nova Scotian population) **X** 100,000

Source: Canadian Laboratory Centre for Disease Control, Ottawa, Report on AIDS, 2000, Health Canada and Chief Medical Officer of Health, NSDoH, 1998 with population estimates from Performance Measurement and Health Informatics, NSDoH, 1999.

69. HIV INCIDENCE PER 100,000 POPULATION- Nova Scotia - 1991 to 2000

Background: Human immunodeficiency virus. Serologic or other evidence of HIV infection in an individual who does not meet the case definition of AIDS. Public Health reports only those cases that are diagnosed in this province. If someone tests positive in New Brunswick, for example, and comes to Nova Scotia for treatment, they are not included in these statistics.

Formula: (The number of people newly diagnosed with HIV (incidence) within the Nova Scotia population / the Nova Scotia population estimate for the same time period) X 100,000.

Source: Canadian Laboratory Centre for Disease Control, Ottawa, Report on HIV, 2000, Health Canada Chief Medical Officer of Health, NSDoH.

70. TOBACCO CONTROL UNIT

71. SMOKING RATES Ages ≥ 15 Years - Nova Scotia and Canada

Background: Adult smoking is a difficult phenomenon to report on, as there are almost as many definitions of adult smoking as there are studies on smoking. This indicator, as it is used here, is a composite measure – made of three different surveys spanning five different years. All of them define "Smokers are those reported smoking cigarettes daily"[7].

[7] Notes on the summary page of the Health Indicators Database, for "Numbers of Smokers", Statistics Canada, December 1996.

Formula: (The number of adult daily smokers / the population estimated for a given time period and a given geopolitical area) **X** 100.

Source: General Social Survey, 1985 and 1991; N.A.D.S. 1989; Health Indicators Database, Statistics Canada, December 1996; and National Population Health Survey, 1994/95 and 1996/97, Statistics Canada, July 1998, Canadian Tobacco Use Monitoring Survey (CTUMS) .

72. SMOKING RATES - Nova Scotia Women Who Smoke During Pregnancy – As Reported Upon Hospital Admission - 1991 to 2000

Background: This measure compares the number of women who smoke during pregnancy to the total number of pregnant women expressed as a percentage. The total number of pregnant women is based solely on those who are in hospital to deliver. It is possible that some pregnant women will not be captured in this manner. This measure also demonstrates the indirect impact of smoking awareness educational programs on expectant mothers.

Formula: (The total number of women (aged 0 to 35 plus years) who report smoking on admission / the total number of women (smokers and non-smokers) who have given birth) **X** 100.

Source: Nova Scotia Atlee Perinatal Database (NSAPD), 2000.

73. SMOKING RATES - Youth Smoking – Ages 15 to 19 for 1999 and 2000 by Province

Background: The Canadian Tobacco Use Monitoring Survey (CTUMS) was developed to provide Health Canada and its partners with timely, reliable and continual data on tobacco use and related issues. The survey's primary objective is to track changes in smoking status and amount smoked, especially for populations most at risk, such as 15-24 year olds.

Source: Canadian Tobacco Use Monitoring Survey (CTUMS) 1999, 2000.

74. ENVIRONMENTAL TOBACCO SMOKE Children's Exposure to Tobacco Smoke at Home – Percentage of Homes with Children aged 0 to 11 where Someone Smokes Regularly, by Provinces & Canada – 1996/97 and 2000

Background: The Canadian Tobacco Use Monitoring Survey (CTUMS) was developed to provide Health Canada and its partners with timely, reliable and continual data on tobacco use and related issues. The survey's primary objective is to track changes in smoking status and amount smoked, especially for populations most at risk, such as 15-24 year olds

Source: National Population Health Survey, 1996/97, Canadian Tobacco Use Monitoring Survey (CTUMS) 2000.

75. TOBACCO CONTROL COMPLIANCE RATES BY REGION/DHA NOVA SCOTIA RETAILERS - 2000/01

Background: The percentage of retailers complying with the requirements of the Provincial Tobacco Access Act and the Federal Tobacco Act.

Formula: (The total number of inspections - the number of retailers warned or charged) / the number of inspections) X 100.

Source: Tobacco Control Unit Annual Statistics, NSDoH.

76. HOME CARE NOVA SCOTIA

77. HOME CARE NOVA SCOTIA - ANNUAL CASELOAD - 1995/96 to 2000/01

Background: Caseload refers to a group of clients managed by one community based care coordinator. A client is admitted to the program when the client has been accepted at assessment, assessed by a care coordinator, assigned to a category, and service delivery (nursing, home support, personal care, oxygen services, or case management) has begun.

Formula: The accumulated total number of clients in the caseload for 1995/96, 1996/97, 1998/99 and 2000/01.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

78. HOME CARE NOVA SCOTIA - ANNUAL CASELOAD – by DHA of Residence - 2000/01

Background: Caseload refers to a group of clients managed by one community based care coordinator. A client is admitted to the program when the client has been accepted at assessment, assessed by a care coordinator, assigned to a category, and service delivery (nursing, home support, personal care, oxygen services, or case management) has begun.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH

79. HOME CARE NOVA SCOTIA - Number of Admissions by DHA of Residence - 2000/01

Background: As stated above caseload refers to a group of clients managed by one community based care coordinator. A client is admitted to the program

when the client has been accepted at assessment, assessed by a care coordinator, assigned to a category, and service delivery (nursing, home support, personal care, oxygen services, or case management) has begun. This measure is reported by District Health Authority.

Formula: The number of admissions to the Home Care Nova Scotia caseload by District.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

80. HOME CARE NOVA SCOTIA - Chronic Home Care Services Admissions - 1995/96 TO 2000/01

Background: Chronic Home Care services provide home support, personal care, nursing, and home oxygen services to persons with assessed unmet needs who are convalescing, chronically ill, disabled, or experiencing debilities of old age. This measure is compared across the Health Districts.

Formula: The number of admissions to chronic Home Care services in Nova Scotia by year.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

81. HOME CARE NOVA SCOTIA - Chronic Home Care Services Admissions - by DHA of Residence - 2000/01

Background: Chronic Home Care Services include home support, personal care, nursing, and home oxygen services to persons with assessed unmet needs who are convalescing, chronically ill, disabled, or experiencing debilities of old age. This measure is compared across the Health Districts and over three years.

Formula: The number of admissions to chronic Home Care services by District.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

82. HOME CARE NOVA SCOTIA - Acute Home Care Services Admissions - 1995/96 TO 2000/01

Background: Acute Home Care Services include nursing services, and may provide personal care and/or home support services to meet the needs of individuals with acute episodic illness that may be treated safely and effectively within the home. Acute episodic illness is an illness or condition of short duration and relatively severe course, which is a pronounced deviation from the normal state of health of the individual.

Formula: The number of admissions to acute Home Care services by year.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

83. HOME CARE - Acute Home Care Services Admissions by DHA of Residence - 2000/01

Background: Acute Home Care Services include nursing services, and may provide personal care and/or home support services to meet the needs of individuals with acute episodic illness that may be treated safely and effectively within the home. Acute episodic illness is an illness or condition of short duration and relatively severe course, which is a pronounced deviation from the normal state of health of the individual.

Formula: The number of admissions of acute Home Care services by District.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

84. HOME CARE NOVA SCOTIA - Number of Clients Receiving Home Oxygen (New Starts) by Region/DHA of Residence 2000/01

Background: "The Home Oxygen Service funds clients of all ages with chronic hypoxemia who require a home oxygen concentrator. ... This service is intended to assist individuals who do not have the financial resources to secure a home oxygen concentrator necessary for more independent functioning in the home or home-like setting."[8] Home Oxygen clients are generally admitted to chronic Home Care services.

Formula: The number of home oxygen starts by District Health Authority by fiscal year.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

85. EMERGENCY HEALTH SERVICES – GROUND AMBULANCE

86. EMERGENCY HEALTH SERVICES – Ground Ambulance – Average Emergency Call Processing and Response Times 2000/01

Background: Long distance trips may be defined as a call that takes the ambulance outside of its primary response zone – for example from one District Health Authority to another.

Formula: The total number of long distance and local trips by District Health Authority for fiscal year 2000/01

Source: EHSNS Communications Centre

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[8] Home Oxygen Service: Procedures and Guidelines, 2nd. Edition, February 1999, home Care Nova Scotia, Nova Scotia Department of Health, page 4.

87. EMERGENCY HEALTH SERVICES – Ground Ambulance – Average Emergency Call Processing and Response Times – 2000/01

Background: The time it takes for Emergency Health personnel to answer an emergency call, dispatch an emergency vehicle, and have the vehicle arrive at the scene of an emergency are each of vital importance to the health and survival of the patient. The longer it takes emergency personnel to respond the greater the risk to the patient. Therefore the measurement of the amount of time it takes to receive a call and dispatch a vehicle and the amount of time it takes to receive the dispatch and arrive on scene is a measurement of the effectiveness of Emergency Health Services.

Formula: Call Processing: from the time an emergency call is received to the time of dispatch of closest vehicle. Response Time: from the receiving the dispatch to arrival on scene. These measurements are made on each call and then averaged per month and calendar year.

Source: EHSNS Communications Centre

88. EMERGENCY HEALTH SERVICES – Ground Ambulance – Number of Calls and Non-Emergency Transports –by Month – 2000/01

Background: One way to measure the utilization of Emergency Health Services Nova Scotia is to measure vehicle usage. In this case the measurement encompasses both emergency calls and non-emergency transports (patient transfers).

Formula: Emergency/Urgent Calls: the total number of emergency/urgent calls per month and per calendar year. Non-emergency Transports: the total number of non-emergency transports per month and per calendar year.

Source: EHSNS Communications Centre

89. EMERGENCY HEALTH SERVICES – Ground Ambulance – Emergency Calls "Top Ten" Chief Complaints – 2000/01

Background: One way to determine equipment and skill requirements for ambulance operation is to identify the most frequently requested types of emergency services.

Formula: The total number of emergency and urgent calls by "Chief Complaints" for fiscal year 2000/01

Source: EHSNS Communications Centre

90. EMERGENCY HEALTH SERVICES – Ground Ambulance – Survival Rates for Out-of-Hospital Cardiac Arrests 1997 – 2000

Background: Persons suffering a cardiac arrest out of hospital have no chance of survival without resuscitation. Only through a combination of prompt Cardiopulmonary Resuscitation (CPR) and emergency response with defibrillation can people be saved from certain death. Therefore, advanced pre-hospital care provided by an emergency health system increases the chance of survival of those who suffer a cardiac arrest outside of hospital. Note: Survival rate refers only to patients who are discharged from hospital neurologically intact.

Formula: (The number of neurologically intact survivors of out-of-hospital cardiac arrests who were treated by EHSNS / the total number of persons suffering out-of-hospital cardiac arrests who were treated by EHSNS) X 100%

Source: EHSNS Medical Director

91. EMERGENCY HEALTH SERVICES – LifeFlight (Air Ambulance)

92. EMERGENCY HEALTH SERVICES – LifeFlight (Air Ambulance) – Missions by Year – 1996/97 to 2000/01

Background A "Mission" is any call where the EHS LifeFlight medical team has had patient contact and therefore generated a patient care record.

Formula: The number of missions by fiscal year 1996/97 to 2000/01

Source: EHSNS LifeFlight Air Program

93. EMERGENCY HEALTH SERVICES – LifeFlight (Air Ambulance) – Missions by Month – 2000/01

Background: A "Mission" is any call where the EHS LifeFlight medical team has had patient contact and therefore generated a patient care record.

Formula: The number of missions by month for fiscal year 2000/01

Source: EHSNS LifeFlight Air Program

94. EMERGENCY HEALTH SERVICES – LifeFlight (Air Ambulance) – Missions Locations – 2000/01

Background: A "Mission" is any call where the EHS LifeFlight medical team has had patient contact and therefore generated a patient care record.

Formula: Total number of missions broken into Nova Scotia and other locations for fiscal year 2000/01. Note: Other includes missions to other Provinces or the United States.

Source: EHSNS LifeFlight Air Program

95. EMERGENCY HEALTH SERVICES – LifeFlight (Air Ambulance) – Missions by Response Type – 2000/01

Background: A "Mission" is any call where the EHS LifeFlight medical team has had patient contact and therefore generated a patient care record.
Inter-Facility: Request for transport originates from a health care facility and patient is picked up from the health care facility.
Scene: Request for transport originates from scene of injury or illness and the patient is picked up directly from the scene.
Scene Inter-Facility: Request for transport originates from the scene of injury or illness and patient is picked up from a health care facility.
Repatriation: The inter-facility transport of a patient, to an equal or lower level of care that returns the patient to their home hospital or the transport of a patient, to receive a higher level of care, from a hospital in the Maritimes to a hospital outside of the Maritimes.

Formula: The number of missions by response type for fiscal year 2000/01.
Source: EHSNS LifeFlight Air Program

96. EMERGENCY HEALTH SERVICES – LifeFlight (Air Ambulance) – Missions by Patient Age – 2000/01

Background: A "Mission" is any call where the EHS LifeFlight medical team has had patient contact and therefore generated a patient care record.
Adult: 16 years and up; Pediatric: 1 month to 15 years; Neonatal: newborn to one month; Obstetric: > 20 weeks gestation; Adult/Ped: patient transported by any combo of the adult and Pediatric team; Adult/Obs: patient transported by any combo of the adult and the Obstetric nurse; Obs/Neo: an obstetric mission in which the patient delivers the baby

Formula: The number of missions by patient age for fiscal year 2000/01.
Source: EHSNS LifeFlight Air Program

97. EMERGENCY HEALTH SERVICES – LifeFlight (Air Ambulance) – Missions by District Health Authority – 2000/01

Background: A "Mission" is any call where the EHS LifeFlight medical team has had patient contact and therefore generated a patient care record.
Note: Scene means request for transport originates from scene of injury or illness and the patient is picked up directly from the scene. IWK means Izaak Walton Killam Health Centre.

Formula: The number of inter-facility missions by District Health Authorities for fiscal year 2000/01. The mission belongs to the DHA where the initiating facility is located.

Source: EHSNS LifeFlight Air Program

98. SERVICE EXPENDITURES

99. EXPENDITURES FOR INSURED SERVICES – 1996/97 to 2000/01 Excludes Administrative Expenses

Background: Insured services include Medicare, Children's Oral Health, Pharmacare (Seniors and Special Assistance Programs), Optometry, and Prosthetics. The measure of total expenditures refers to the total amount paid for these services. Data provided for 1996/97 are 'date of payment'. Data beginning 1997/98 are at 'date of service' except Dental. Dental date of service data began in 1999/00.

Formula: Total amount paid for insured services per fiscal year as expressed in millions of dollars.

Excl: This measure excludes services provided to members of the Royal Canadian Mounted Police (RCMP) and Armed Forces personnel, as their services are funded federally. Rural Stabilization and Emergency Room 111 are excluded from 1996/97 data. Administrative expenditures for program delivery are excluded. Pharmacare includes both the Department of Health expenditures and Seniors' contributions.

Source: MSI Annual Statistical Tables, NSDoH Health Economics, NSDoH.

100. MEDICARE - NUMBER OF PHYSICIAN SERVICES PER BENEFICIARY - 1997/98 to 2000/01

Background: This measure expresses the number of services physicians provide per beneficiary (insured person who receives services) . Data provided are 'date of service'.

Formula: The total number of physician services /the total insured population receiving services (beneficiary) .

Incl: This measure includes services for Nova Scotia residents receiving services outside Nova Scotia.

Excl: This measure excludes services provided to members of the Royal Canadian Mounted Police (RCMP) and Armed Forces personnel as their services are funded federally. Excludes Non-Patient Specific (Diagnostic Imaging, Pathology, Internal Medicine) services as these claims are submitted in bulk; no demographic data are available.

Source: MSI Annual Statistical Tables, NSDoH Health Economics, NSDoH.

101. MEDICARE - PHYSICIAN SERVICES EXPENDITURES PER BENEFICIARY 1997/98 to 2000/01

Background: This measure illustrates the amount paid for Medicare services on a per beneficiary basis (a beneficiary is an insured person who receives services).

Formula: The total amount paid for Medicare services / the total insured population receiving services (beneficiary) .

Incl: This measure includes services for Nova Scotia residents receiving services outside Nova Scotia.

Excl: This measure excludes services provided to members of the Royal Canadian Mounted Police (RCMP) and Armed Forces personnel, as their services are funded federally. Excludes Non-Patient Specific (Diagnostic Imaging, Pathology, Internal Medicine) payments as these claims are submitted in bulk; no demographic data are available.

Source: MSI Annual Statistical Tables, NSDoH Health Economics, NSDoH.

102. MEDICARE - POPULATION PER GENERAL PRACTITIONER (GP) - Fee-for-Service Only - The Total Number of Insured Population per General Practitioners in Nova Scotia - 1996/97 to 2000/01

Background: A general practitioner is a licensed physician functioning as a General Practitioner who receives at least one dollar per year for Fee-for-Service claims. This measure shows the number of insured people for every one general practitioner in the province. Insured Population is from Statistics Canada's population data as of July 1st of each year.

Formula: The total number of insured population per fiscal year / the number of physicians functioning as a General Practitioner in Nova Scotia.

Source: MSI Database, NSDoH Health Economics, NSDoH.

103. MEDICARE - NUMBER OF GENERAL PRACTITIONERS (GP's) - Fee-for-Service Only - by Location: Urban, Rural, and Total - Nova Scotia 1996/97 to 2000/01

Background: A general practitioner is a licensed physician functioning as a General Practitioner who receives at least one dollar per year for Fee-for-Service claims. This measure illustrates the number of insured people for every one general practitioner in the province. "Urban areas are defined as areas with a population over 35,000. These areas include: Sydney Urban area within a perimeter bounded by North Sydney, Sydney City, and Glace Bay; The Halifax/Dartmouth area [is] within a perimeter bounded by Halifax, Middle Sackville, and Dartmouth."[9]

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[9] Footnote 2, Table 3.0 (continued) : Physicians' Services' Fee-For-Service Payments by Specialty in Urban and Rural Areas 1995/96 and 1996/97, Insured Programs Management, Nova Scotia Department

Formula: The number of physicians functioning as a general practitioner in Nova Scotia by location, urban or rural by fiscal year.

Source: MSI Database, NSDoH Health Economics, NSDoH.

104. PHARMACARE - NUMBER OF PRESCRIPTIONS PER BENEFICIARY - Nova Scotia 1997/98 to 2000/01

Background: This indicator illustrates the number of prescriptions paid under Pharmacare for each beneficiary (a beneficiary is an insured person who has received a prescription). Data provided are 'date of service'.

Formula: The total number of prescriptions paid under the Pharmacare Program / the total number of insured beneficiaries.

Encl: This measure excludes nursing home residents where their facility supplies prescriptions. It further excludes those services provided to members of the Royal Canadian Mounted Police (RCMP) and Armed Forces personnel, as their services are funded federally.

Source: MSI annual statistical tables, NSDoH Health Economics, NSDoH.

105. PHARMACARE - AMOUNT PAID FOR PRESCRIPTIONS PER BENEFICIARY - Nova Scotia 1997/98 to 2000/01

Background: This indicator illustrates the amount paid for prescriptions under Pharmacare per beneficiary (a beneficiary is an insured person who has received benefits). Data provided are 'date of service.

Formula: The total amount paid for prescriptions under the Pharmacare Program / the total number of insured beneficiaries.

Incl: This measure includes both the Department of Health expenditures and Seniors' contributions.

Excl: This measure excludes Nursing home residents, where their facility supplies prescriptions. It further excludes those services provided to members of the Royal Canadian Mounted Police (RCMP) and Armed Forces personnel, as their services are funded federally.

Source: MSI annual statistical tables, NSDoH Health Economics, NSDoH

106. CHILDREN'S ORAL HEALTH - % OF CHILDREN RECEIVING ANNUAL DENTAL CHECK-UPS - Ages 3 to 9 - 1996/97 to 2000/01

Background: This measure illustrates the number of children (ages 3 to 9 years) receiving annual check-ups covered under the Children's Oral Health Program, Denticare programs, as expressed as a percentage of all

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of Health, Draft Copy. Bracketed additions were added by the Performance Measurement and Health informatics Section, Nova Scotia Department of Health.

insured children (ages 3 to 9 years) per fiscal year. Insured population is from Statistics Canada as of July 1st each year. An annual check-up includes an annual check-up and/or recall exam.

Formula: (The number of children (ages 3 to 9 years) receiving annual check-ups covered under the Children's Oral Health Program / the total number of insured Nova Scotian children (ages 3 to 9 years)) **X** 100 per fiscal year.

Source: MSI Database, NSDoH Health Economics, NSDoH.

107. CHILDREN'S ORAL HEALTH - % OF CHILDREN RECEIVING ANNUAL DENTAL CHECK-UPS - Ages 3 to 9 - by DHA of Residence - 2000/01

Background: This measure illustrates the number of children (ages 3 to 9 years) who are covered under the Children's Oral Health Program, Denticare programs, receiving annual check-ups as expressed as a percentage of all insured children (ages 3 to 9 years) in each District Health Authority for the current fiscal year. Insured population is from Statistics Canada as of July 1st each year. An annual check-up includes an annual check-up and/or recall exam.

Formula: (The number of children (ages 3 to 9 years) receiving annual check-ups covered under the Children's Oral Health Program in each District Health Authority / the total number of insured Nova Scotian children (ages 3 to 9 years) in each District Health Authority) **X** 100.

Source: MSI Database, NSDoH Health Economics, NSDoH.

108. CHILDREN'S ORAL HEALTH - AVERAGE NUMBER OF DENTAL RESTORATIONS PER INSURED - Ages 3 to 9 - 1996/97 to 2000/01

Background: This measure illustrates the number of dental restoration services for children (ages 3 to 9 years) who are covered under the Children's Oral Health Program, Denticare programs, expressed as an average of all insured children (ages 3 to 9 years). Insured population is from Statistics Canada as of July 1st each year.

Formula: The number of dental restoration services for children (ages 3 to 9 years) covered under the Children's Oral Health Program / the total number of insured Nova Scotian children (ages 3 to 9 years).

Source: MSI Database, NSDoH Health Economics, NSDoH.

109. CHILDREN'S ORAL HEALTH - AVERAGE NUMBER OF DENTAL RESTORATIONS PER INSURED – Ages 3 to 9 - by DHA of Residence – 2000/01

Background: This measure illustrates the number of dental restorations services for

children (ages 3 to 9 years), in each District Health Authority, who are covered under the Children's Oral Health Program, Denticare programs, receiving dental restorations as expressed as an average of all insured children (ages 3 to 9 years) in each District Health Authority. Insured population is from Statistics Canada as of July 1st each year.

Formula: The number of children (ages 3 to 9 years) in each District Health Authority receiving dental restorations covered under the Children's Oral Health Program / the total number of insured Nova Scotian children (ages 3 to 9 years) in each District Health Authority.

Source: MSI Database, NSDoH Health Economics, NSDoH.

110. WOMEN'S HEALTH

111. CAESAREAN SECTIONS PER 100 DELIVERIES - Nova Scotia 1995/96 to 2000/01 and Canada 1998/99

Background: This indicator measures the rate of performance of caesarean sections expressed a percentage of all deliveries. The Case Mix Groups (CMG's) 601 to 604 were used for caesarean sections and 601 to 604 and 606 to 611 were used for deliveries.

Formula: (The total number of caesarean sections / the total number of deliveries) X 100 per fiscal year.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

112. CAESAREAN SECTION RATE - By DHA of Hospitalization - 2000/01

Background: This indicator measures the rate of caesarean sections expressed as a percentage of all deliveries by the women's DHA of hospitalization. The following Case Mix Groups (CMG's) 601 to 604 were used for caesarean sections and 601 to 604 and 606 to 611 were used for deliveries. The provincial target is set to a maximum of 20%.

Formula: (The total number of caesarean sections by the women's District of hospitalization / the total number of deliveries in Nova Scotia per District) X 100 per fiscal year.

Source: NSDoH CIHI DAD 1995/96 to 2000/01.

113. MAMMOGRAPHY SCREENING - Percentage of Women Screened for the First Time (Aged 50 to 69 Years) – Nova Scotia 1991/92 to 2000/01

Background: This indicator measures the number of women ages 50 to 69 who have had at least one mammogram for breast cancer screening in a given

fiscal year, as administered by the Nova Scotia Breast Screening Program.

Formula: (The total number of women ages 50-69 who have had one mammogram during a fiscal year (new recruits) / the yearly Nova Scotia population estimate women ages 50-69) **X** 100 per fiscal year.

Source: Nova Scotia Breast Screening Program database, NSDoH.

114. BREAST CANCER INCIDENCE RATES – Rates Per 100,000 Age-Standardized to the 1991 Canadian Population (Female) - Nova Scotia & Canada 1980 to 2000

Background: Incidence rate trends associated with breast cancer can provide important planning information regarding treatment and prevention programs, especially as death from chronic conditions becomes more prevalent.

Formula: ((The number of women who were diagnosed with breast cancer (new cases) in Nova Scotia / the population estimate in Nova Scotia) **X** Standardizing Process) **X** 100,000 per calendar year.

Source: Nova Scotia Cancer Registry, NSDoH.

115. BREAST CANCER MORTALITY RATES – Rates Per 100,000 Age Standardized to the 1991 Canadian Population (Female) Nova Scotia & Canada 1980 to 2000

Background: The mortality rate of breast cancer for women shows the rate at which women have died from breast cancer.

Formula: ((The number of women who died from breast cancer in Nova Scotia / the population estimate in Nova Scotia) **X** Standardizing Process) **X** 100,000 per calendar year.

Source: For 1950 to 1990 Nova Scotia and 1950 to 1992 Canada - Health Indicators Database, CIHI Health Care in Canada - A First Annual Report - Statistics Canada, 1996 and 2000; for Nova Scotia from 1990 to 1998 - Nova Scotia Vital Statistics 1990 to 1997, Cancer Bureau LCDC Health Canada

116. CERVICAL CANCER INCIDENCE RATES – Rates Per 100,000 Age-Standardized to the 1991 Canadian Population (Female) - Nova Scotia & Canada 1980 to 2000

Background: Incidence rate trends associated with cervical cancer can provide important planning information regarding treatment and prevention programs, especially as death from chronic conditions becomes more prevalent.

Formula: ((The number of women who were diagnosed with cervical cancer (new cases) in Nova Scotia / the population estimate in Nova Scotia) X Standardizing Process) X 100,000 per calendar year.

Source: Nova Scotia Cancer Registry, NSDoH.

117. CERVICAL CANCER MORTALITY RATES – Age-Standardized Rates Per 100,000 (Female) Population Nova Scotia and Canada 1990 to 2000

Background: Mortality rate trends associated with cervical cancer can provide important planning information regarding treatment and prevention programs, especially as death from chronic conditions becomes more prevalent.

Formula: ((The number of women who died from cervical cancer in Nova Scotia / the population estimate in Nova Scotia) X Standardizing Process) X 100,000 per calendar year.

Source: Nova Scotia Cancer Registry and Canadian Cancer Statistics for the Canadian data.

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